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DRUG ADDICTED BABIES: WHAT CAN BE DONE?

HEARING

BEFORE THE

SUBCOMMITTEE ON CHILDREN, FAMILY, DRUGS AND ALCOHOLISM

OF THE

COMMITTEE ON LABOR AND HUMAN RESOURCES UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

ON

EXAMINING THE EFFECTS OF DRUG USE ON UNBORN CHILDREN AND HOW TO COMBAT THE SITUATION

OCTOBER 9, 1989
INDIANAPOLIS, IN

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DRUG ADDICTED BABIES: WHAT CAN BE DONE?

MONDAY, OCTOBER 9, 1989

U.S. SENATE,
SUBCOMMITTEE ON CHILDREN, FAMILY,
DRUGS AND ALCOHOLISM
OF THE COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The subcommittee met, pursuant to notice, at 12:00 p.m., at Fulton Junior High School, Indianapolis, IN, Senator Dan Coats presiding.

Present: Senator Coats.

OPENING STATEMENT OF SENATOR COATS

Senator COATS. The Senate Subcommittee on Children, Family, Drugs and Alcoholism will come to order. I want to welcome and thank each of you for being here this morning on behalf of Chairman Dodd and Chairman Kennedy of the full committee. I have the opportunity to convene and chair this particular hearing. I bring apologies from my Senate colleagues.

As you probably have seen on weekend news, the Senate schedule has been substantially altered and interrupted. We are supposed to be on a week of recess this week. We have convened a number of conferences, two Senate hearings and other programs throughout the State of Indiana primarily on the subject of drugs and alcoholism and its effects on our young people. Some of my colleagues had hoped to join us, but the Senate schedule has just been turned topsy-turvy, we are going to have to interrupt the recess and not only finish the weekend schedule of this past weekend but go into another one this coming weekend.

Nevertheless, we are here. This is an official hearing. We are most pleased to have distinguished witnesses who I will introduce in a moment.

There is a small but vocal group of people, some conservative, some liberal, who recommend that we legalize drugs and be done with the matter. They argue that it is absurd to spend money on a drug war just to keep people from harming themselves, but through this hearing we will learn that substance abuse is not a victimless crime. In fact, it is a growing threat to the health and well-being of our most vulnerable citizens, our children.

When a mother uses drugs it is child abuse through the umbilical cord. This type of abuse leaves its permanent imprint on the lives of a staggering number of drug-exposed infants running into

the hundreds of thousands each year, nearly 11 percent of all U.S. newborns.

Already health-care services are showing signs of strain. Private clinics are closing, citing the high costs of treating crack babies and other cocaine-related health problems. Social services have been overrun with cases in which substance abuse is a major factor. In the Nation's capital nearly 90 percent of all cases in child protective services are substance-abuse related.

The effects of drug use on unborn children is traumatic. Some suffer strokes in the womb when they are born with a birth weight of as little as 1½ pounds. Their skin can be so sensitive that they cannot be touched or held by anyone. Many are unable to stop kicking and moving their arms. But perhaps most of all, drugs have stripped many of the mothers of these children of all parental concern. Many don't name their babies, leaving that to nurses. Some never come to visit. Some hospitals must send telegrams to uninterested parents to have them sign for a postmortem when the child dies.

Drug use is not just a crime that affects the users, it is an enemy of nurture. It is an enemy of families and it is an enemy of the helpless innocent.

We have a very full agenda today, so I will not take any more time. I look forward to hearing from experts on the details of this problem and how we can meet it, and I would finally like to say how pleased I am to be joined by someone who is coordinating our Nation's war on drugs, an outspoken advocate of an all-out war on drugs, someone not afraid to challenge conventional wisdom nor so-called "Washington wisdom," which is often far from conventional.

[We will now receive a prepared statement by Senator Orrin Hatch for the record:]

Prepared Statement of Senator Hatch

Senator Hatch. Mr. Chairman, I am pleased that you and the Chairman of the Judiciary Committee scheduled this joint committee hearing today on the impact of drugs on our families and children. Since the President presented his strategy to the American people, we have had a number of hearings in the Labor and Human Resources and Judiciary Committees. I have found that these hearings confirm one important point—we must fight drug abuse without partisan wrangling.

Drug abuse has no borders. It is pervasive in our schools, in our workplaces, and in our communities. And, the subject of today's hearing strikes at the very heart of the problem: drugs and their impact on our families and children.

We need to continue to focus our attention on the broad societal problems of alcohol and drug abuse. We know about the impact of alcohol and drugs on the fetus. We are beginning to better understand the cost of fetal alcohol syndrome to our Nation. We are beginning to see the horror of children born addicted to cocaine, the impact on their very fragile nervous systems, and the stories of the long-term impact on their learning abilities. Mr. Chairman, we are just seeing the tip of the iceberg on this issue.

But, we can do more. Families need to support school and community programs that strengthen the ability of children to say no to drug and alcohol use. And, perhaps most important, families need to help their children fight the temptation of the streets to make a quick buck selling drugs. The Utah State University's Cooperative Extension Service and the Cottage Program International, through a program called Families In Focus, are providing services to high risk youth and their families in Utah and other States. In Utah alone, this program has reached over 3,500 high-risk youth and their families through over 1,500 trained volunteers. They are helping to keep families together, to keep family members off drugs, and to control the rampant use of drugs in our communities.

Mr. Chairman, families are the foundation of our culture. The breakdown of the family has been blamed for many of society's problems. But, I have faith and confidence that where family structure has broken down, it can be rebuilt; and, when families are unable to cope, we will see people coming forward to help.

I look forward to hearing from our distinguished witnesses today.

Senator COATS. I appreciate very much the attendance of Secretary Bennett here in Indianapolis to hear our story, to share our pain and to work with us to find solutions to a very real problem.

Secretary Bennett, welcome to Indiana. [Applause.]

HON. WILLIAM BENNETT, DIRECTOR, OFFICE OF NATIONAL DRUG CONTROL POLICY, WASHINGTON, DC

Dr. BENNETT. Thank you very much. It is a much warmer welcome than Jim Kelly and Buffalo Bill got in Indiana. [Laughter.]

I thank you, Senator, very much. I am very pleased to be here for your committee. So I guess, Mr. Chairman, as you know, I spent the best part of four weeks testifying before the Congress, and as you know, I kept hoping for the end of it. I used the punch line in that old joke, "I am enjoying as much of it as I can stand." But you asked me for one more bit of testimony, but you promised we could do it outside of Washington, here in Indianapolis and to listen to some expert witnesses, and that was an invitation I was very happy to accept.

I commend you, Mr. Chairman, for this opportunity, this hearing. I commend you for your attention to this issue. I commend you for your constant attention as a Senator, as a Congressman, to the importance of the family and the importance of those principles and values of our society which, of course, are the bedrock of the upbringing of children.

I have been saying since I was named Director of the Office of National Drug Control Policy, or "Drug Czar," that, in fact, there is a very simple solution to this terrible drug problem. We affirm the moral authority of the family, the church and school, and we will have lots less drug use than we have right now. That, however, is a long-term solution. I think you and I and many others share that view and want to do everything we can to strengthen those fundamental institutions, but in the meantime we have a heck of a problem on our hands with the drug problem, and we need to do everything we can to address it in the short term, in the mid term and in the long term.

I don't want to take very long, because I want to hear from the witnesses, have the opportunity to ask them some questions. Let me just say I share with you the belief that it is the sight of these children, these babies, these helpless infants, in a situation where, because of exposure to drugs, they find themselves at risk. That, to me, brought home in a way nothing else could this problem of drugs in America.

It is well, Mr. Chairman, to cite the problem, in television and newsreel coverage, of these children to grip the American people and make them realize that we do not have a victimless crime abroad in the land but a very serious, very fundamental one that requires an immediate response. I am not sure that anything has had more effect on the conscience of America than the sight of these babies. So I look forward to this discussion.

Thank you for your invitation and your warm welcome, and I will now join you up there. I am very interested to hear what this distinguished group of witnesses has to say.

Senator COATS. Thank you, Mr. Secretary.

The Secretary will join us at the panel table, and I will call forward the first panel, which consists of Judy Burnison, Dr. Alan Golichowski and Michael Dorris, and have them come forward to present their testimony to us.

Just so that all of you understand the format, Secretary Bennett is on an extremely tight schedule, will be sitting through the first panel, taking some questions from the press at a very brief break after the first panel, then catching a plane to Chicago in his tour of what he likes to describe as the "Heartlands" as you go into Iowa and Nebraska and a couple of other States before returning to Washington. So we will excuse him after the first panel, but I want to thank all the witnesses for this participation and particularly that our panel, and if we would just take an abbreviated summary of your remarks so that we can leave some time for questions, we would appreciate that.

Judy Burnison is Executive Director of the National Association for Perinatal Addiction, Research and Education from Chicago, IL. Judy, we welcome you and look forward to your testimony.

STATEMENT OF JUDITH C. BURNISON, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF PERINATAL ADDICTION, RESEARCH AND EDUCATION, CHICAGO, IL

Ms. BURNISON. Thank you. Mr. Chairman, the National Association for Perinatal Addiction, Research and Education was founded in 1987 in response to a growing awareness by clinicians, researchers, social service professionals, educators, and attorneys that there was an acute need for an interdisciplinary forum to address a very complex and growing problem of perinatal addiction in the long-term outlook for children who have been exposed in utero to licit and illicit drugs.

There recently has been a rapid increase in the concern for infants born to alcohol- and other drug-using women. The reasons for this concern are easily understood when current statistics are reviewed. A recent study by our association of 36 hospitals from around the country showed the overall incidence of substance

abuse in pregnancy was 11 percent with a range of 0.4 percent to 27 percent.

As further studies have been conducted, we have found that rural areas of the United States have not been spared. For example, in Wenatchee, WA, 20 to 25 babies per week are delivered at the community hospital. Among these, three to four per week are reported to the Child Protective Services team due to having cocaine in their urine at birth.

The belief that the problems connected with women using drugs during pregnancy occur only in lower socio-economic, urban minority groups and not in the white middle-class, private sector is erroneous. Dr. Ira J. Chasnoff, President of NAPARE, recently reported the findings of a study conducted in Pinellas County, Florida. Pinellas County, Florida, is Clearwater and St. Petersburg.

This was the first comprehensive population-based study of substance abuse during pregnancy. Because of the county's demographics, it could represent a microcosm of many other communities across the United States. Blind urine tests were conducted on every woman who enrolled for prenatal care at five Pinellas County public health clinics and every woman who entered similar care at twelve private obstetric practices in Pinellas County from January 1 to June 30, 1989. A total of 715 women were tested; 380 in the clinic and 335 in private care. The tests were identified only by zip code, race, and age of mother.

Records from the Pinellas County Health Department during the same time period were reviewed regarding all women reported for drug or alcohol abuse during pregnancy. Zip code, race, and drug-use pattern (types of drugs consumed) were recorded by the researchers and compared with the two groups of public and private patients.

Results of the study showed: 14.8 percent of all the women tested positive for alcohol, marijuana, cocaine and/or opiates. There was no significant difference in the rates of the private or public patients: 13.7 percent in the private sector and 16.3 percent in the public sector. The two drugs found most frequently in all the women were marijuana and cocaine.

The incidence of the use of each individual drug was also similar, except for cocaine having a slightly higher incidence among women in the public health group.

Among black and white women (both public and private patients), the rate of positive tests for drug use was 15 percent. (Hispanic and Oriental women were not included in these statistical analyses because of the small number in the study.) The rate of positive tests for drugs among white women was 15.4 percent; the rate for black women, 14.1 percent.

In both the total population of women (public and private patients) and the total population of black and white women, marijuana was the drug used most often. In the population of black and white women, black women showed a higher rate of cocaine use: 7.5 percent versus 1.8 percent. White women used more marijuana: 14.4 percent versus 6 percent for black women.

In the 6-month period of the study, 133 pregnant women were reported for substance abuse to the county health authorities. Forty-eight were white, 85 were black. There were no significant differ-

ences in socioeconomic status, and patterns of drug use were similar. In analyzing the proportion of black and white women reported to the total number of births among black and white women, it was found that a black woman was 10 times as likely to be reported for substance abuse in pregnancy as compared to a white woman. This was in contrast to the fact that a white woman was just as likely to have used drugs or alcohol during pregnancy.

This information presents a challenge to governmental bodies that are attempting to develop child protection laws which will cover substance abuse during pregnancy to be sure that medical evidence of drug use is the basis for determining risk and not preconceived notions of risk in certain populations.

Senator COATS. Thank you very much, Ms. Burnison.

I think what we will do is hear from each of the witnesses and then we can direct questions to any and all. So, Dr. Golichowski, thank you for your presentation.

Dr. Golichowski is Chief of Maternal and Fetal Medicine at the Indiana University Medical Center in Indianapolis.

STATEMENT OF DR. ALAN M. GOLICHOWSKI, CHIEF, MATERNAL AND FETAL MEDICINE, INDIANA UNIVERSITY MEDICAL CENTER, INDIANAPOLIS, IN

Dr. GOLICHOWSKI. Dr. Bennett, Mr. Chairman, it is indeed a great privilege and an honor to come before the subcommittee to discuss the problem of drug use in pregnancy and to emphasize the importance of education, early detection and early treatment in confronting this problem. Two great forces now threaten the well-being of pregnant women and children. The first is the great tragedy of infant mortality. The second is the overwhelming problem of drug abuse. For many women and children these problems are intertwined. Cocaine, crack, heroin, alcohol, speed and a multitude of other drugs threaten the lives and the health of many young women, but they do more. When they are taken during pregnancy, they can cause devastating effects in the unborn child, effects which last a lifetime.

There are scores of drugs that, if taken during pregnancy, can have life-long effects on the child. One, for example, is DES. When a small amount of this drug is taken during pregnancy, it can cause cancer decades later in a child born of that pregnancy. Another example is alcohol, which, if taken during pregnancy, can exert profound effects on a fetus, effects which result in a lifetime of mental retardation.

Education has eliminated the use of DES in pregnancy. The education and early intervention are making inroads into the use of alcohol in pregnancy, but now we are confronted by another drug, cocaine, which, when taken in pregnancy, has even more disastrous effects on the child. In my opinion, we must combat its use with an even more vigorous program of education, detection and early intervention.

Cocaine causes intense constriction of blood vessels, stopping the flow of blood to vital organs. When cocaine reaches the fetus, it can cause strokes and other damage to the developing nervous system. This damage is frequently permanent.

In recent months my colleagues and I have had to deal with increasing frequency with the problems of cocaine use in pregnancy. We have been faced with pregnancies in which the brain of the fetus has been destroyed and turned to liquid by multiple strokes caused by the use of cocaine. This damage was detectable by ultrasound imaging months before birth. We have cared for women whose children will have limited use of their arms and legs because of prenatal damage to their nervous systems by cocaine. Such damage is apparent at birth and frequently before birth. We have cared for women whose children were spared these disabilities but who will be plagued by others, by hyperirritability and learning disorders. Telltale signs of these problems are frequently evident before the newborn leaves the hospital.

Mr. Chairman, we do not need further studies to demonstrate the effects of alcohol and cocaine use during pregnancy. Every study concludes that the effects are disastrous, disastrous for the fetus and, I must add, disastrous for the mother, for how much harder must it be for the mother to recover from the drug abuse if she comes in for treatment late in pregnancy only to find that the fetus is already affected.

We urgently need the efforts of national leaders such as yourselves, along with the efforts of health professionals to develop and implement comprehensive, effective, and humane programs to prevent the use of cocaine in pregnancy. We need to educate women about the effects of this drug in pregnancy. We need to be able to detect and provide treatment for addicted women before they become pregnant. If pregnancy occurs, we desperately need programs that can intervene immediately to provide treatment. Once the fetus is affected, it is too late. The damage cannot be undone.

Mr. Chairman, we do need ways of measuring the extent of the problem and of our success in treating it. I wish I could inform this committee that we have the statistics to clearly delineate the problem of crack use in pregnancy in the State of Indiana and the city of Indianapolis. We do not have the whole story. We do know that the problem here is similar to that reported in other parts of the United States.

Some evidence of the magnitude of the problem is revealed in a study that was conducted a year ago by Dr. Beth Norman, by Dr. Richard Hansell, and Dr. Michael Evans of the Indiana University School of Medicine which we submit to the committee. This study found that 3 percent of women in labor who consented to have their urine anonymously checked, had traces of cocaine in their urine. Seven percent of these women, when interviewed, admitted to the use of cocaine sometime during their pregnancy. Twelve percent of women who had pregnancies complicated by placental abruption or premature separation of the placenta, a problem known to be related to the use of cocaine, had positive urine tests for cocaine. One out of four of these women gave a history of cocaine use during pregnancy.

I wish to emphasize that this study was completed a year ago, and I personally believe the problem is much more pronounced at present. If our community is similar to others whose experience has been reported, the current prevalence of cocaine use has risen and is now at least twice as high.

Mr. Chairman, women who are likely to use cocaine in pregnancy need to be treated and treated effectively. One of my personal concerns, however, is that in waging this war on drugs we consider very carefully all the effects of proposed programs. We need to consider the effects on the practice of medicine, on preventive health care and especially on the women affected.

I am deeply concerned, Mr. Chairman, that if physicians are required to report cocaine use during pregnancy to legal authorities for the purpose of criminal prosecution of pregnant women, many pregnant women will no longer seek prenatal care. If addicted pregnant women are threatened by criminal prosecution when they seek prenatal care, they will be driven from the health care system. The effect will be more crack babies, more fetal alcohol babies, and increased infant mortality.

I believe that, if addicted, pregnant women are given immunity to criminal prosecution if they seek treatment for their addiction by immediately entering prenatal care and treatment programs that the long-term outcome will be better for their infants.

Mr. Bennett, Mr. Chairman, I wish you all the success in solving this problem of drug abuse in America. Obstetricians and maternal fetal specialists want to work with you to help make this Nation a safer place for future generations of children.

[The prepared statement of Dr. Alan M. Golichowski follows:]

PREPARED STATEMENT OF DR. ALAN M. GOLICHOWSKI

Mr. Chairman:

It is indeed a great privilege and an honor to testify before this subcommittee hearing. This committee hearing has come at a most opportune time and is exceedingly important because two great forces are threatening the well-being of pregnant women and children. The first of these forces is the great tragedy of infant mortality. The second is the overwhelming problem of drugs in the United States in general and the specific devastating impact that drugs are having on future generations of Americans. The use of cocaine, crack, heroin, alcohol, speed, and a multitude of street drugs that are taken during pregnancy cause a lifetime of devastating effects for children born under these circumstances.

There are several hundred drugs, that if taken during pregnancy, can have devastating effects on the child for many years to come after their birth. Think of Diethylstilbestrol. When a small amount of this drug is taken during pregnancy it can cause cancer in the child born of that pregnancy decades later. The effect of alcohol taken during pregnancy causes a lifetime of mental retardation for a child. We are now confronted with a drug which when taken in pregnancy has even more disastrous effects on the child.

Cocaine is now used by literally thousands of pregnant women. This highly addictive drug now further destroys future generations of Americans. In my opinion what we need are comprehensive programs of education, detection, and early treatment of mothers-to-be who are affected by this drug.

In the past six months my colleagues and I have had to deal with pregnancies in which the brain of the fetus has been destroyed and turned to liquid by strokes caused by the use of cocaine. We have cared for women whose children will have limited use of their arms and legs because of prenatal damage to their nervous systems by cocaine. And we have cared for women whose children are spared these problems only to have lives plagued by learning disabilities. We are having to deal with problems such as these with ever increasing frequency.

It is my hope that you will hear the plea from obstetricians and maternal fetal specialists throughout the entire United States that we must attack and bring into submission, the problem of crack in pregnancy with every possible approach. We desperately need the efforts of national leaders such as yourself, along with the efforts of the health professions, to deal with this problem in a humane and comprehensive way.

Mr. Chairman, we do not need any further studies on the effect of alcohol and cocaine use during pregnancy. Every study concludes the effects disastrous for the fetus. What we need are programs to prevent the use of these drugs in pregnancies. It is my sincere hope and plea that a major national effort can come forth that will attack the problem of preventing cocaine use in pregnancy. Mr. Chairman, the problem can be stated most clearly. If a woman does not drink nor take drugs during pregnancy they do not have a crack baby or a child with fetal alcohol syndrome. It is a tragedy for any woman to become an addict of either alcohol or cocaine. It is an extreme tragedy when the child that she is carrying will have the lifetime consequences of her addiction. We simply must protect unborn children.

I wish I could inform this committee that we have the statistics to clearly delineate the problem of crack use in pregnancy in the State of Indiana and the City of Indianapolis. We do not have the whole story. We do know that the problem here is similar to that reported in other parts of the United States. Some evidence of the magnitude of the problem in our community of Indianapolis is revealed in a study that was conducted a year ago by Dr. Beth Norman, Dr. Richard Hansell, and Dr. Michael Evans of the Indiana University School of Medicine which we submit to the Committee. These investigators found that 3% of women presenting in labor had traces of cocaine in their urine. Seven percent admitted to the use of cocaine during pregnancy. Twelve percent of women who were seen for placental abruption, or separation of the placenta from the uterus before delivery, which is known to be related to the use of cocaine, had positive urine tests for cocaine; 25% of these women gave a history of cocaine use. I wish to emphasize that this study was completed a year ago and that I personally believe the problem is much more pronounced at present. If our community is similar to those whose experience has been reported, the current prevalence should be twice as high.

One of my personal concerns, Mr. Chairman, is that in this war on drugs you consider very carefully the legal effects of legislation on the practice of medicine and on preventive health care. I am deeply concerned Mr. Chairman, that if physicians are required to report cocaine use during pregnancy to legal authorities and this results in criminal prosecution of the pregnant woman, that many pregnant women will no longer seek prenatal care. If a pregnant woman is threatened by criminal prosecution when she seeks prenatal care, then the effect will be to drive women who are addicted to drugs away from the health care system and the long-term effect will result in more crack babies, more fetal alcohol babies, and increased infant mortality. I believe that the long-term outcome will be better for their infants if addicted pregnant women are given immunity from criminal prosecution if they seek treatment for their addiction by immediately entering prenatal care and treatment programs. Without a doubt pregnant women who are addicted to

cocaine and refuse to come in for prenatal care and refuse to enter a treatment program to protect the fetus should be dealt with vigorously and effectively. However, if addicts would come forth immediately when possibly pregnant and enter a treatment program, they should be immune from criminal prosecution.

Mr. Chairman:

I wish you all the success in solving the problems of drugs in America. We obstetricians want to work with you to help make this nation a safer place for future generations of children.

Senator COATS. Thank you, Doctor.

Michael Dorris is a professor at Dartmouth College and also author of "The Broken Cord, a Family's Ongoing Struggle with Fetal Alcohol Syndrome."

Mr. Dorris, we are pleased you are here, and we appreciate very much your testimony.

STATEMENT OF MICHAEL DORRIS, AUTHOR AND PROFESSOR, DARTMOUTH COLLEGE, HANOVER, NH

Mr. DORRIS. Thank you, Mr. Chairman.

Senator Coats, Mr. Bennett, I testify as a parent who has been forced to become a kind of expert on the subject that I didn't know much about a few years ago. When, "The Broken Cord, a Family's Ongoing Struggle with Fetal Alcohol Syndrome" was published last summer I had no idea what kind of reaction to expect, but the very personal story of my 21-year-old son's physical learning problems were a direct result of his natural mother's alcohol consumption during her pregnancy be of interest to readers, draw the attention of book reviewers or sound the small roar to makers of public policy.

Adam's life was not melodramatic. It had no uplifting climax in which, like Rocky, he triumphed over his adversity by sheer acts of will. Rather, my son was, as much as it is possible to be, typical of the 80 to 100,000 children, by very conservative estimates, born in this country each year permanently and unnecessarily impaired by maternal drinking.

He had a host of chronic bodily illnesses, seizures, poor eyesight and hearing, curvature of the spine, bad coordination, to name only a few, and borderline mental retardation. Even as an adult, with years of special education behind him, he cannot make change for a dollar, tell time, live independently, or understand the plot of a TV movie.

Adam was and is a victim, an innocent harmed by carelessness, ignorance or weakness before he ever drew a breath of air. He will not get better, and his security will forever hinge on the kindness and professional care of others. He will never understand precisely what he is missing, so he is not consciously unhappy or dissatisfied, but he is often lonely, always confused and rarely charming. He lacks the drive and motivation of mentally handicapped people romanticized by "LA Law" or "Life Goes On". He is completely without malice or guile, but he also lacks foresight, common sense, and a notion of what matters in the long run.

The poison that ruined his life and dramatically changed that of every member of his family is legally sold and its use and abuse is increasing all over the world among women of child-bearing age. Many doctors and prenatal advisers, unaware of or unheeding the latest scientific research and warnings of the Surgeon General, the American Medical Association and the March of Dimes, still continue to counsel that it is OK for a pregnant woman to drink in moderation. These health workers have not yet received and transmitted the crucial message: There is no guaranteed safe level of alcohol consumption during pregnancy or breast feeding for some women, and there is no way to predict who these are in advance.

Even a few drinks of wine, beer, or liquor during crucial times of gestation can apparently cause irreparable life-long damage to their unborn offspring.

To me the most wrenching response is coming in the form of hundreds of letters to parents, young and old, adoptive and natural, of all ethnic and socioeconomic groups. Adam's trouble, it turns out, is, unfortunately, far from unique. In fact, with his placement in a fine group-living home, with his steady job as a dishwasher at a truck stop, with good medical care and access to paid social services, Adam seems to be among the very fortunate FAS victims, most of whom wind up on the streets as homeless or in jail.

The mail keeps coming, the stories each different but so much the same: The 29-year-old Scandinavian daughter in Michigan recently who was diagnosed with fetal alcohol effects, with two bad marriages and three FAS children to her credit. The black 9-year-old boy in Oregon whose mother, now 7 years a recovering alcoholic, can't toilet train him. The blond, blue-eyed toddler in Connecticut labeled "failure to thrive" who sits listless and vacant in a crib full of educational toys. The Chinese-American teenager in California with an IQ of 55 who will always be institutionalized. The native American twins adopted by Peace Corps volunteers in Colorado who became inveterate shoplifters, showed no signs of remorse, went on to more serious crimes and are now both in the same prison.

The loved, doted-upon babies from everywhere that grew up flunking arithmetic, were kicked out of one school after another and became themselves hooked on booze and other drugs perpetuating the cycle, because, Mr. Chairman, the person most at risk to give birth to a FAS baby is herself a FAS victim who, because of her lack of abstract thinking, cannot understand simple warnings about the dangers of drinking during pregnancy. Desperate, exhausted, guilty parents write me in hopes of any new lead, a cure, a magic panacea that will solve the deadly flaws of their children, and I reply with biblically reverent references with sympathy and understanding but with no satisfactory answers.

Parts of the brain or the body that, due to alcohol or other drugs during gestation, were never formed cannot be recreated after birth. The only solution—and this only for children not yet conceived, not yet born—is prevention. A mother who abstains from all alcoholic beverages from conception through the cessation of breast feeding will not, cannot have a FAS baby—period. No celebratory drink, no night on the town, no escape from reality is worth the grinding gears of a child's stunted life, the loss of his or her human potential. Before a pregnant woman gives in to the temptation of "one more drink," let her spend an afternoon in a day-care center populated by FAS children, let her talk to a parent of a FAS child, let her talk to my adult son.

One final point: A woman does not conceive a baby alone, and while both FAS and fetal alcohol effects apparently are the products of what the mother imbibes while the fetus develops, the father is not without responsibility. Some research indicates that the sperm of a male alcoholic may suffer chromosomal damage and

that his children, especially the boys, may themselves be more prone than average to chemical dependence.

Furthermore, a husband or lover can contribute to a healthy pregnancy by supporting his partner in her necessary sobriety. Nine months is a relatively short period for a woman and man to refrain from alcohol abuse when the benefit is a full, unimpeded life for their son or daughter.

I hope you will spread the word and do something about this. Next to life itself, drug- and alcohol-free pregnancy is the most valuable gift two parents can ever give their child.

[The fact sheet of fetal alcohol syndrome by Michael Dorris follows:]

FACT SHEET ON FETAL ALCOHOL SYNDROME

• *WHAT IS FETAL ALCOHOL SYNDROME?*

FETAL ALCOHOL SYNDROME (FAS) is the name given to the permanent, lifelong damage done to a fetus if its mother has imbibed an unhealthy amount of alcohol during her pregnancy. It is a term used by scientists only since the middle 1970s to describe a recurrent set of physical and behavioral problems common in the offspring of female alcoholics. FETAL ALCOHOL EFFECT (FAE) is the term for any impairments resulting from maternal drinking less than the full range of symptoms.

• *WHAT IS LIKELY TO BE AFFECTED BY FAS?*

Most of the alcohol a mother drinks passes through her placenta and becomes part of her growing baby's environment. By the time a woman herself feels the effects of her drinking, her baby may well already be drunk or passed out. Repeated exposure to alcohol will likely result in damage to the fetus. After birth, FAS is manifested both physically (including but not limited to malformations of the bones, heart, and major organs; vision and hearing impairments; poor coordination) and behaviorally (damage to the developing brain that produces certain kinds of learning problems, such as a difficulty with abstract thought processes). In some respects, the types of problems are tied to the trimester of pregnancy during which the mother drank alcohol, with physical effects coming more from first and second trimester drinking and emotional/learning effects stemming more from third trimester drinking.

• *WHAT ARE THE TELL-TALE SYMPTOMS IN AN FAS BABY?*

An FAS baby will more than likely be premature, slight, and will possibly "fail to thrive." In severe cases, it may show signs of detoxification as soon as the umbilical cord is severed. There is a "typical" FAS face – the signs include a smooth philtrum (indentation above the lip), a relatively small head circumference, a recognizable constellation of facial features (including but not limited to low nasal bridge, small midface, epicanthic folds of the eyelids, thin and reddish upper lip), and a slow pattern of growth. As the child matures, he or she may become hyperactive, may find it especially hard to learn from experience, and will likely have trouble with such academic subjects as mathematics and such concepts as telling time and dealing with money.

• *WHAT ABOUT SMOKING AND OTHER HAZZARDS?*

While it is true that smoking and environmental pollutants can also harm a developing fetus, compounding fetal alcohol effects, it has been demonstrated that alcohol alone is sufficient to cause severe impairments.

• *WHO GETS FAS?*

FAS exists in the children of women of all races, social classes, and nationalities. Estimates are that upwards of 70,000 fetal alcohol impaired babies are born every year in the United States and many times that number worldwide. Many adults with FAS are in prison or are homeless, and most children with FAS are defined as learning disabled or retarded, though IQ can range from 35 to over 100.

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• CAN FAS BE CURED OR PREVENTED?

FAS has been called the #1 preventable form of mental retardation and the #1 preventable birth defect. To date, research strongly suggests that if a woman abstains from all alcohol before conception, through pregnancy, and until the end of breast-feeding, her child will not have fetal alcohol syndrome, regardless of the woman's past drinking behavior. Furthermore, if a woman has been drinking during her pregnancy and stops, the chances that she will bear a healthy baby greatly increase. However, because FAS is the result of a lack of proper fetal development, once it exists it cannot, ever, be cured. It can only be imperfectly treated, symptom by symptom, for the life of the patient.

• If A CHILD HAS BEEN DIAGNOSED AS FAS, WHAT THEN?

An FAS child (or adult) requires a highly structured educational and living environment. He or she learns by rote, repetition, and behavioral modification, and will likely require a variety of medications to control hyperactivity, seizures, and other related symptoms. He or she may be more prone than the normal individual to become chemically dependent and is at extremely high risk for breaking the law in later life.

• WHAT ARE THE SOCIAL COSTS OF FAS?

The costs of FAS can measured in terms of the tragic, enormous lost potential of its victims or in terms of the hundreds of millions of dollars society pays for their medication, frequent institutionalization or forced incarceration.

• IS THERE ANY SAFE AMOUNT OF ALCOHOL A WOMAN CAN CONSUME DURING PREGNANCY?

Some women apparently can drink in moderation during pregnancy and still bear "normal" children, yet current evidence suggests that even as little as two drinks per week -- of wine, beer, or liquor -- can cause measurable damage to the fetus. Older mothers, stressed mothers, mothers with poor nutrition, mothers who smoke, or mothers who use drugs are particularly at risk. The Surgeon General of the United States, the Royal College of Physicians in England, the American Medical Association, and the March of Dimes (among other organizations) all counsel that there is no "safe" amount of liquor for a pregnant woman or a nursing mother. Abstinence is the only guarantee against an FAS baby. The ultimate question is this: would you give your baby an ounce of pure gin the day after it is born? If not, why do it the day or week or month before?

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Senator COATS. Thank you, Mr. Dorris, and thanks to all of our panelists for their testimony. Because of our limitations on Dr. Bennett's time, I am going to ask him if he would ask the questions here in the panel until such time as he needs to leave. So, Dr. Bennett.

Dr. BENNETT. Thank you, Mr. Chairman. To the panelists, thank you very much for your brevity or cogency and your eloquence. You have all spoken well and, I think, cogently in the matter.

I may or may not take advantage of your expertise in the questions I want to ask you, but while listening to you I jotted down a few, and you may or may not know that my job is to develop a strategy and continue to revise the strategy for fighting drugs in this society.

By law, alcohol and some other things are not within my purview, but they are certainly within the purview of this committee, and because the links are so close, I am vitally interested in this question as well. But let me ask the three of you, who all have substantial experience with this topic, should you put yourself in my shoes or the chairman's shoes, some specific questions.

What would you do? What would you have us do? What would your advice to us be, bearing this in mind: I hear the cautions from you. We live, as is obvious to you and a blessing to all of us, in a free society. People are largely free to do what they want to do. We do not have to ask permission from the State to take a drink and, indeed, in our free society, even though it is against the law, it is increasing, it is all too easy to get your hands on drugs.

Voluntarism, the condition under which people exercise their voluntary choice in this society, give people, because it is a principle of this country, liberty and broad parameters of action. To someone who is called "Drug Czar," to someone who is chairman of a subcommittee, Senator of the United States, what do we think in terms of? Do we think in terms of public policy? Do we think in terms of the law? Can we use the law? Can the laws be used effectively here?

I have very clearly heard, Doctor, your caution to us not to make physicians subject to criminal prosecution to keep this conversation between mother/pregnant addict and doctor confidential or private, any part of this at all. What would you have us do?

Just one last thought, because Mr. Dorris made a very interesting comment toward the end, something I have thought about a number of times. I know of one college that used to invite its freshmen, in a course in ethics, to an emergency room in the hospital on a weekend to see the results of drunk driving just so people can see first hand what drunk driving brings about. You made the suggestion about perhaps parents or to-be parents should go to, as you say, a FAS day-care center and see this. Should this be what we should do? Should we invite people, coerce people, if we want to suggest that, before becoming parents, they do this kind of visiting? Should people perhaps go to a crack house and see what goes on in a crack house? Should this be part of the high school curriculum? Take the question any way you like. We are in a position for having to come up the best we can with laws, public policies, funding patterns. What do we do about this?

Ms. BURNISON. I would like to respond to that. It is the position of our association that several things should happen. No. 1, one of the main stumbling blocks is physicians. Physicians are not trained to take a lifestyle or drug-abuse history. They find it uncomfortable, particularly in the private care practices. They feel they are going to offend the patient, that they will lose patients. There are just a number of excuses.

No. 2, in the medical school curriculum there is very little taught about drug abuse—period. There is practically nothing about substance abuse in pregnancy, and we are talking alcohol and other drugs. Residents, interns, have very little experience or knowledge about substance abuse. We need to get this type of information into the medical school curriculum and start teaching potential doctors and nurses and health care professionals about substance abuse in pregnancy. If we could train physicians to do a lifestyle and drug-abuse history, then it would be the responsibility of the physician to start acting as a case manager and start providing services and know where services are available for recommending that these women go. If we can provide enough services for this woman to get off of drugs or alcohol, we have a better chance for the outcome of the fetus to be normal.

Also, if the woman is in a crack house or she is living in an environment that is drug-infested, then we need to provide services in the residential care area. There are just a handful of residential treatment centers in the country. We need a lot of them. If a woman is living in an environment where it is not conducive to her to eliminate drugs or alcohol because the rest of her "family," whatever, that exists, is also using drugs or alcohol, you have to take the woman out of the environment and put her in another environment and rehabilitate her.

We recently have just received a large Federal grant to open up a residential program in the State of Illinois in Chicago. There are many other residential programs that are starting to be opened. I think we see in the future that the basic outcome of the child is what we are all looking for; then we have to start providing enough services for the mother and the family to rehabilitate the mother and the family so the outcome of the child will be better.

Dr. BENNETT. Let me ask you this, and I will give Dr. Golichowski a chance to respond. I think most of us agree that there ought to be available opportunities and places and help for people who want help. What do we do with the hard case—and, unfortunately, there is more than one—of the woman or parents who do not want to avail themselves of it?

Ms. BURNISON. First of all, you have to realize there are practically no drug rehabilitation programs in the country available for pregnant women. So therefore if the woman is pregnant and she wants to seek help, the doors are closed. The traditional drug rehabilitation centers, outpatient, inpatient, do not seek pregnant women.

Dr. BENNETT. Indeed, maybe there should be more. You may not believe there are, but I have been to two in just my travels. Let's assume for the sake of argument there should be more. Do you think it follows that the availability means that everyone will seek it out? I want to know what you do in the hard case. I don't know

the answer to this, by the way, but I am seeking guidance on it. If you are looking at a situation where the damage that is going to be done is something you can't call back, it's there forever, what do you do in the hard case? Obviously you do all you can to encourage people to come in voluntarily. Doctor.

Dr. GOLICHOWSKI. I have no answer to what you do in a hard case. I think we have enough cases that we can deal with where the woman would be interested if given the opportunity and we should worry about that.

Ms. BURNISON. I agree with that.

Senator COATS. Mr. Dorris.

Mr. DORRIS. I have several responses, and I don't have the answer either, and I don't envy your job. I think we are talking here about women who have decided to carry their child to term, first of all. That's a point that must be made, and I think it should also be pointed out that at least in fetal alcohol syndrome, women who give birth to FAS babies are themselves greatly at risk. The few studies that exist suggest that these women don't live long themselves. Many do not make it to their child's fifth birthday. So these children become the responsibility more often than not of the State and of adoptive parents, at an enormous cost in the billions of dollars.

Second, I think that it is a known fact that a woman who has had a FAS baby, we know that her body does not metabolize alcohol, and her chances of having a second FAS baby, if she continues to drink, are eight out of ten. So this is a known fact. This is something that can be predicted, that the statistics are that she won't live long and that she will bear another FAS child if she continues to drink.

As I have thought about this question and talked about the book, I guess I come up with another question: If there was a person who was walking her child across the street without reference to traffic lights and the first time she did it her child was killed and she did it again and again and again and each time the child was killed, is it the responsibility of society to simply stand on the sidelines and watch and bury the child? I don't think so. There has to be found some balance between the individual rights of the already living and those that are going to live because she has decided to carry to term.

In a large society that is very hard. In a small community such as on the Pine Ridge Reservation in South Dakota it is somewhat easier, because people know each other and there, under the laws of the Pine Ridge Tribe, there is a statute that provides for child abuse for a woman who has had a FAS baby, is pregnant, intends to give birth and continues to drink, that she can be mandated to a detoxification center, and I thoroughly agree with that, and as you have said, there need to be more detox centers, especially aimed particularly for pregnant women.

Dr. BENNETT. Do either of you want to comment on Professor Dorris's response?

Dr. GOLICHOWSKI. I would agree. I would come back to your first statement, and that is the problem that we are singling out certain drugs and leaving others behind, and we have a society that openly promotes the use of certain drugs, and we have to find other ones

illicit. I think that certainly we have done it experimentally, we have been trying to prohibit the use of one of those important drugs and it didn't work, but I think we need to come back a little bit closer to the center and not promote its use nearly as much as we do.

Dr. BENNETT. Give me the prognosis for the future. I was reading the other day someone was saying that increased alcohol use—and Professor Dorris was talking about increased use of a variety of illicit drugs, I think the phrase was—all of this consumption of drugs is going to give us a resurgence of orphanages and foundling homes for the future, that probably we will see tremendous growth in these institutions, that because of these patterns of behavior and because of a kind of abuse—I think it's fair to call it that, that you all have testified to so eloquently to—that occurs beforehand, often it is followed by abuse or neglect, what one of you was talking about, often these babies are not named, and so on, and that what we are going to see is what everyone thinks of as the State's ability to act wisely and sensitively in this area and the State will be, by last resort, the keeper, the parent, the guardian of these children. Is that what we are facing, 50,000 foster children in New York, I think I read the other day? How do you see it?

Mr. DORRIS. These are problems that grow geometrically, because victims give birth to victims. FAS mothers who can't be counseled have more children, statistically start earlier, continue having children later in their lives, drink during their pregnancies, are abusive after birth.

It is also complicated by the fact that one of the mental retardation problems of fetal alcohol syndrome and cocaine, as I understand it, is a problem with abstract thinking, so that the whole issue of moral choices of understanding culpability is truly impaired. I mean, it's begun to be used as a legal defense in certain criminal cases of a person who is diagnosed as FAS or FAE, having committed a crime and being judged, in effect, insane.

I think we are going to see an enormous increase in crime that is absolutely pointless, has no conscience to it and is habituated because people who have this problem don't learn from their mistakes. It is not their fault, but it is at society's expense.

Senator COATS. If I could just interrupt, doesn't that lead to a situation where programs for outpatient treatment tend to become very suspect in terms of our ability to really achieve results? I can understand the mother who doesn't understand the nature of some occasional wine or drinking here and there on a social basis, but for someone that is addicted, whether it's crack or alcohol or whatever other substance, isn't, number one, the very nature of the definition of addiction something that they can't control and, number two, the results of the addictive substance on their thinking something that rational programs, treatment centers, and so forth, can't really affect in a positive way without some type of control over that individual's freedom of choice in terms of how they conduct their lives?

I am not advocating anything here. I am just following up on what I think is the crux of the problem and the question that none of us really has good answers to.

Mr. DORRIS. When I adopted my son as a single parent—I adopted three children as a single parent before I got married, a single parent for 10 years—I was a complete believer in the notion of nurture over nature, that every child is a blank slate and could be whoever he or she should be. I sound like a commercial, but I am still a believer in nurture and in the balance of nurture and nature, but I think that the definition of nurture has changed.

Nurture begins not even with conception, it begins in the environment in which the society welcomes a new life, and I think that this is a problem that we are talking about today that is not easily isolated to, as my colleagues pointed out, to social groups or ethnic groups or economic groups, but it's pervasive within our society, and it is a social problem that this committee, I think, that the full committee as well as the subcommittee, addresses every day. It is part of the whole malaise that exists within our society in terms of believing in a future.

Senator COATS. Well, we are running a little short on time here. We have an ambitious program, four panels, and we need to take a brief break. I would ask the media at this point if they would like to move to the room where we are holding the press availability, and while they are doing so, Dr. Bennett, if you want to make a closing statement or a follow-up question to the panelists, this probably would be a good time. We have a few minutes.

Dr. BENNETT. I would like to thank the panel again. I would like to associate myself with the last comments by Professor Dorris. He is right, I think one of the fundamental obligations of any society is posed by the fact of natality, that the new generation comes into the world and what we think of it, and while it wasn't chilling or frightening, or didn't have the chilling or frightening headline attached to it, headlines I saw from a study of a public opinion survey a few years back had the effect on me, just the shift over a period of 15 or 20 years from adults in the United States and their attitude toward children, their attitude toward what they would be prepared to sacrifice for their children, do for their children and the priority of children and just a statistical shift of some 30 or 40 points, and who is entitled to more attention, your own self-realization or the needs of your children? And it just underwent a big change, somewhere between the 1960's and the 1980's. I think it has a lot to do with the current condition.

The thing I keep being reminded of, while I was Secretary of Education and this job as well, is that it—it probably sounds too simple to conclude on, but I think it is important: is that children don't raise themselves, they have to be raised, and that means somebody has to be crazy about them, wants to spend time with them—not just quality time, but time—because they take time and their idea of when they need time is not necessarily ours, and that caring for them starts a long time before birth and it starts in that whole environment that the culture has, its whole attitude toward children. And I don't think, Mr. Chairman, until we address that, we are really going to get at this problem.

I want to thank you very much and thank the panel very much.

Senator COATS. Thank you very much for your participation, and we will be back shortly. [Applause.]

(Short break.)

Senator COATS. Thank you very much for your patience. We apologize for having to interrupt the committee hearing.

We now turn to Panel II, and I would like to ask the witnesses to come forward: Dr. Haywood Brown, Associate Professor, Louisiana State Medical Center. Anne Ruhmkorff, Registered Nurse, Lifelines of Indianapolis. And Holly Waggoner. We appreciate all of you testifying before us this morning.

I think we will do what we did in the first panel and have each of you testify, and then we will open it up for questions. And, Dr. Brown, we will start with you. Thank you for being with us.

STATEMENT OF DR. HAYWOOD L. BROWN, ASSOCIATE PROFESSOR, LOUISIANA STATE MEDICAL CENTER, NEW ORLEANS, LA

Dr. BROWN. Thank you. Mr. Chairman, I am a maternal fetal medicine specialist, treating problem pregnancies. I am assistant director of Obstetrics at Charity Hospital in New Orleans. I am also in charge of the high-risk prenatal clinics and treat many pregnant women, including those on cocaine and other drugs.

It is a pleasure and an honor to be here today to testify on the extreme importance of prenatal detection and treatment and intervention programs for pregnant addicts. We must have the necessary education, detection, and treatment programs if we are to prevent "crack babies."

With the increasing abuse of cocaine and other drugs by the general population, cocaine use by pregnant women and women of child-bearing age has also increased. As a result of this trend, the number of women who abuse substances such as cocaine during their pregnancies has increased significantly.

The full implications of cocaine abuse in the child-bearing years and concurrent with pregnancy are unknown. In addition to the possibility of life-threatening cardiovascular and central nervous system complications in women using cocaine, the abuse of this drug during pregnancy presents substantial hazards for their infants. It has been clearly documented that cocaine is associated with adverse perinatal outcome as evidenced by increased perinatal morbidity and mortality when this drug is abused during pregnancy.

Physiologically, cocaine use in pregnancy is associated with a decrease in blood flow to the uterus and to the placenta. It causes maternal hypertension, elevation of the maternal pulse and constriction of fetal blood vessels. These physiologic changes may lead to perinatal hazards which may include fetal cerebral vascular accidents, or strokes, utero-placental insufficiency, intrauterine growth retardation or diminished fetal growth, placental separation or abruption, premature labor and delivery and certainly fetal death.

In addition, a congenital anomaly syndrome has also been documented which is characterized by significant fetal limb defects, as has been testified to. In addition to that, infant mortality in women who abuse cocaine during pregnancy is increased. It has been documented that the incidence of sudden infant death syndrome is 30 times higher than in the general infant population.

Random urine screening of unselected prenatal populations for drugs reveals a significant incidence of women using cocaine. Charity Hospital in New Orleans is a large urban hospital utilized by Louisiana State University School of Medicine and Tulane University School of Medicine for medical student and residency education. It serves a combined obstetric population of approximately 5,000-6,000 deliveries per year. A preliminary program was implemented which involved random urine drug screening of women presenting for obstetric care. Preliminary results showed positive screening tests for cocaine in 7 percent of these women in an unselected population.

Studies such as the one performed at Charity Hospital in New Orleans are not unique. In fact, in a larger survey of an indigent prenatal clinic population in Boston, 18 percent of women were classified as cocaine users and 27 percent as marijuana users. In this Boston survey, 24 percent of the women whose urine screens were positive for cocaine denied use of the drug.

Another finding at our hospital, Charity in New Orleans, relates to the problem of this premature placental separation, placental abruption, which has been clearly shown to occur with cocaine use and which often leads to fetal death and stillbirth. Preliminary results at Charity Hospital revealed that 10 percent of women who presented with unexplained placental abruption had positive urine screening for cocaine.

In these women with positive urine cocaine results, the placental abruption may be of sufficient magnitude to result in fetal death. It is believed that maternal increase in blood pressure, or maternal hypertension, especially the sudden rise in blood pressure which characteristically occurs with cocaine use, may increase this risk of placental separation.

A number of other institutions have found a similar incidence of placental separation in association with cocaine use.

It should be noted that even though women were clearly identified in this study as being positive for cocaine, as many as 50 percent denied cocaine use.

These findings have prompted more extensive use of drug screening in any pregnant patient presenting to the Charity Hospital obstetric unit who shows evidence of drug abuse. Institution of this policy for identification of drug users in pregnancy is especially critical, in that at Charity Hospital, as in many other institutions serving primarily an urban population, the overwhelming majority of drug-abusing women fail to seek prenatal care. The reason for this inadequate prenatal care in drug abusers relates to a multitude of psychosocial factors, one of which includes the fear of having their drug addiction revealed.

Since inadequate or no prenatal care is so often a problem in substance-abusing patients, the early identification of such women helps to implement the social and medical interventions necessary to improve the outcome of their pregnancies. The identification process is especially important for the undelivered mother who will probably continue to abuse drugs unless a vigorous intervention program is undertaken.

Obviously, the discovery of substance abuse late in pregnancy or after pregnancy complications have occurred does little to address

the issue of prevention. There is no doubt that early identification of pregnant drug abusers and entry into prenatal care and drug treatment programs is crucial if we are to expect any impact on the perinatal effects of substance abuse.

One of the best models for an interventive approach to the management of maternal substance abuse is the Perinatal Center for Chemical Dependence at Northwestern University in Chicago and the Harbor-UCLA Medical Center in Torrance, California. The goal of such a center is to eliminate or decrease the abuse of substances such as cocaine both during pregnancy and after delivery. Data from those centers has shown that cocaine-abusing women enrolled in such a program achieve a greater gestational age at delivery, or lower incidence of preterm births, a higher birth weight and a lower incidence of premature placental separation and congenital anomalies when compared to cocaine abusers not enrolled in such a program. Without a doubt, cocaine-abusing pregnant women who receive no or little prenatal care have significantly increased perinatal morbidity when compared to those receiving comprehensive interventive prenatal care.

We must capitalize on the greater motivation of many of these substance-abusing women to discontinue drug use during pregnancy, because motivation for discontinuing drug use may never be higher than it is during pregnancy.

By providing medical and psychosocial counselling services during pregnancy, we may be able to reduce some of the high cost of medical care for infants of drug-abusing women. The goal at Charity Hospital in New Orleans, as in many other institutions who have identified a large substance-abusing population, is to follow through with such prenatal programs for pregnant drug abusers, emphasizing a multidisciplinary team approach to management. Thank you.

Senator COATS. Thank you very much, Dr. Brown.

Anne Ruhmkorff.

STATEMENT OF ANNE RUHMKORFF, R.N., LIFELINE OF INDIANAPOLIS, INDIANAPOLIS, IN

Ms. RUHMKORFF. Thank you. Mr. Chairman, I would like to deviate slightly from my prepared statement in order to discuss with you specific problems of drug and alcohol use which we see at Lifelines, in order to talk a little bit more about intervention programs.

Much has been said this afternoon about the problem of maternal drug dependency and subsequent neonatal cocaine addiction, and it is obvious that drug abuse during pregnancy is a serious problem. But I feel that this hearing must also address the long-term needs of these babies and the consequences of parental drug and alcohol abuse on children of all ages.

As the Assistant Administrator of Lifelines of Indianapolis, I have seen first hand the devastating effects of drug and alcohol abuse. At Lifelines of Indianapolis we at our rehabilitation hospital which provides subacute transitional care for infants and children with technological and rehabilitative needs.

It has been well documented that maternal drug abuse can lead to prematurity. Drug abuse combined with poor nutritional health

of the mother and a lack of prenatal care resulted in the birth of a very premature, 25-week-old infant. This child developed serious respiratory problems which required the use of a ventilator to survive. He subsequently developed a common lung disease most commonly known as bronchopulmonary dysplasia. He was hospitalized in a special care nursery for 9 months and was subsequently transferred to Lifelines of Indianapolis' rehabilitation hospital. He continues to require a ventilator to breathe and has serious developmental delay. He has developed hydrocephalus, which is water of the brain, and has required surgical placement of a tube in his brain to drain the fluid. His long-term prognosis is poor, and he will probably require lifetime placement in a nursing home.

His mother, who suffers from poor health herself, also drug dependency and poverty, has only visited this child once in the last year. Parents who use drugs have also been shown to provide inadequate supervision of their children. The home environment of drug-dependent families fosters juvenile delinquent behaviors because of the lack of parenting in the home.

We have a 7-year-old child who was attempting to break into a soft-drink machine with his friends when the machine fell on him. He is now paralyzed from the neck down. He also requires a ventilator to breathe, but he is alert and fully aware of his environment. At Lifelines he gets around in an electric wheelchair and attends school every day. This child is fully able to be sent home with nursing support, but we cannot do this because his mother is a drug dealer and is usually in jail.

The last example I would like to offer concerns the effects of maternal alcohol abuse. At age 1½ this child suffered a fractured neck in an automobile accident after his mother had been drinking, got into a fight with the father and she whisked him and his younger brother off in the car. The car seat wasn't used, and the child broke his neck when the car crashed. He, too, is ventilator-dependent and will be so for the rest of his life.

These are just three examples of the tragic effects of maternal drug and alcohol abuse on children of all ages. While we cannot document it statistically, we believe that many of the head injury victims from child abuse occur while the abuser is under the effects of drugs or alcohol.

Only 1 percent of the patients that we have received have been drug-addicted infants. After researching this topic I could find little evidence of significant occurrence of drug-addicted infants in our area, and it appears from a recent poll of hospitals that administrators who document, approximately 12 drug-addicted infants were born during the last 12 months. It seems that Indianapolis has a much lower rate of drug-addicted infants than the national average.

These facts, though, cannot lull us into a false sense of security. First, there is no active drug-screening program of neonates and, second, a distinction must be made between drug-addicted infants and drug-exposed infants. Prenatal and postnatal drug screens are not likely to identify all the infants who have been exposed to drugs in utero. Cocaine is cleared from adult urine in about 24 hours, so routine prenatal testing may not pick up the occasional user.

Definitely, many pregnant women may stop alcohol or drug use after they know they are pregnant. Unfortunately, critical fetal development and injury to the brain can occur before the time the mother realizes she is pregnant. Infants exposed to cocaine in utero can suffer from strokes in their brain which may go undetected.

The use of prenatal drug testing is fraught with many problems, the greatest of which is it may drive these women away from prenatal care altogether. I support postnatal testing, but only for identification of the infant to assure appropriate medical follow-up and intervention. Postnatal screening should not be used to indict or convict the mother. To turn every mother of a drug-positive baby in and institute a CHINS procedure for child abuse services would overwhelm our welfare system and create a demand for foster home placement that we are ill-equipped to handle. Marion County presently only has 300 foster care families with a weekly waiting list of approximately 50 to 75 children.

There is a critical shortage of black foster families, and the turnover in foster care families averages about 50 percent per year. We cannot guarantee a better life for these infants if they are placed in and out of foster homes. Interventions aimed at the infants' and mothers' problems jointly are considered to be the best. Parent education is of paramount importance. The care giver of a drug-exposed or addicted infant must be committed and willing to deal with an infant who is extremely irritable, difficult to feed and unresponsive to the care-giver's attention.

Programs must include prenatal and postnatal addictive care. Such programs should include obstetrical care, psychological care, drug rehabilitation during and after the pregnancy. These mothers must be taught infant care, nutrition, family planning and special care techniques to enhance the growth and development of their infants. Because most drug-dependent mothers have not had an adequate role model for parenting, parenting skills must also be taught.

The drug rehabilitation program should include peer support and counseling with other mothers of like infants. Follow-up in the home by public health nurses can be utilized to monitor compliance with the infant's health needs as well as the mother's drug rehabilitation program.

Finally, I find it extremely important that once these infants become identified, they become eligible for Public Law 99–457. Public Law 99–457 is an amendment to the Education and Handicapped Act. Only one of these programs provides for early intervention services to meet infantile development needs and includes individualized family service planning and case management to assist families in gaining access to needed services. This program is scheduled for implementation in 1990. I feel it is imperative that drug-addicted, exposed infants be classified under these programs as children at risk and that this program serves as the basis for parent compliance.

The filing of a CINS, a child in need of services, should not be instituted on the basis of a positive drug test but rather for what it was intended, a child in need of services. The mother of a drug-addicted, exposed infant should not be indicted until after she has demonstrated a failure to comply with the infant intervention program and/or drug rehabilitation program. Thank you.

[The prepared statement of Ms. Ruhmkorff follows:]

PREPARED STATEMENT OF ANN K. RUHMKORFF

Drug and alcohol abuse in the United States is now recognized and acknowledged as a significant societal problem. The use of illicit drugs and alcohol occurs in all segments of the population, regardless of race, ethnicity or socioeconomic status. Drug use, especially cocaine, during pregnancy is no longer an unusual phenomenon. In fact, there has been an alarming increase in the last five years (1).

Statistics reported in 1987, indicated that five million people in the United States regularly use cocaine (2). This represents a five-fold increase in use during the past ten years. One in ten people have tried cocaine. Cocaine is the number one illicit drug used by women of childbearing age (3).

A recent study by the National Association for Perinatal Addiction Research and Education surveyed 36 hospitals across the country and found that at least 11% of women in the hospitals has used illegal drugs during pregnancy. Ten to twenty percent of deliveries test positive for cocaine (4). The most alarming statistics were reported at a California conference on neonatal care and drug exposure, which stated that an incidence of 18 to 21% positive drug screens in one local hospital (5).

Nationwide authorities estimate that approximately 400,000 babies are born addicted annually. Some physicians believe that as many as two-thirds of the children born with cocaine in their systems go undiscovered because hospitals do not routinely screen all newborns for drug levels. (6)

While cocaine is the drug most frequently associated with prenatal drug use, cocaine users typically use a combination of other drugs (Valium, opiates, amphetamines and marijuana) in addition to alcohol (7). It is extremely difficult to ascertain the frequency and amount of drug use during pregnancy.

The initial task of health care professionals is to identify drug-exposed infants. Withdrawal symptoms are well documented in infants born to heroin addicted mothers; however, there is some controversy concerning the presence of a cocaine withdrawal symptoms. Whenever perinatal exposure to drugs is suspected, urine toxicology screens of both mother and infant should be performed. Common clinical signs of prenatal cocaine exposure include: hyperirritability, poor feeding patterns, abnormal suck and swallow, increased respiratory and heart rates, tremors, frequent startles and irregular sleeping patterns. These symptoms persist beyond the first few weeks of life and may be more indicative of Central Nervous System changes rather than a withdrawal pattern.

Cocaine addicted infants also have a higher rate of Sudden Infant Death Syndrome (SIDS), as much as 15% greater than the general population. These drug exposed infants are also at risk for a wide variety of medical complications, behavioral and developmental disabilities. Furthermore, these problems may become lifelong disabilities, which may include: learning disabilities, slower intellectual development and delayed language development.

Of grave concern is the inability of these infants to respond appropriately to their mother. The infant is unable to participate in interactive reciprocity, a component of the attaching process. To establish attachment (bonding) a newborn must respond in some way to the mother by initiating eye contact, grasping or cuddling. The newborn's behavior affects the resulting behavior of the mother. Studies have shown that the behavior of the newborn directly affects the caregiving he receives (8). In effect, a negative cycle may be set up in which the behavior of the poorly organized, irritable, high risk

infant may suppress the optimal caregiving pattern necessary to facilitate his or her own recovery. The feelings of frustration and inadequacy that parents may experience in dealing with their fragile, yet unresponsive infant may predispose them later to physical child abuse.

Health care professional have developed interventions to enhance infant development and to decrease the atypical behavior patterns they exhibit. These include special positioning and handling strategies to decrease tremors, startling and extensor tone and feeding techniques to decrease oral defensiveness and normalize sucking behavior. Parent education is of paramount importance in enhancing normal infant development as well as ensuring a strong parent-infant bond. Parent education should begin as soon as possible, so that parents can learn appropriate and effective care giving. Unfortunately, most drug dependent mothers have not had an adequate role model for parenting and therefore need to be taught basic parenting skills in addition to these special care techniques. It is important for parents to see the positive characteristics and strengths that their infant possesses, rather than only focusing only on the weaknesses.

Without early intervention to normalize growth and development, there is an increased risk of creating a generation of children with long term learning disabilities and behavioral problems. The care of drug exposed infants requires a committed caregiver (mother, relative or foster parent) who is willing to learn and practice specific techniques of infant care and deal daily with an infant who is extremely irritable, difficult to feed and unresponsive to the caregiver's

attempts at affection. This surely is not realistic for most drug dependent mothers, who suffer from low self-esteem and use drugs to escape from their problems. Discharging these infants from the hospital without a thorough assessment of the home environment, successful completion of a parental education program and active participation in an effective drug rehabilitation program may result in catastrophic injuries later in the child's life from abuse or lack of supervision.

The most frequent form of physical abuse seen in children less than two years of age is head injury. This type of injury occurs in families stressed by acute or chronic problems, such as unemployment, poverty, drug and alcohol abuse, and families characterized by long standing disturbances in interpersonal relationships, such as previous child abuse. Head injuries from child abuse are often severe, shaking injuries with devastating outcomes. Children under one year of age are given poor prognosis for recovery because of the associated brain damage and visual deficits. Additionally, these infants are typically not brought in for medical care until after they become symptomatic, rather than immediately after the injury. This costly delay may be due to the parent's fear, guilt or denial of the abuse. Because of this delay and further delays in investigating the child abuse case, it is extremely difficult to document the role of drugs or alcohol in the abusive episode.

Cases of nonintentional accidental injury similarly cluster in stressed families with limited personal and physical resources. Accidents, the less extreme end of the continuum of pediatric social dysfunction, frequently represent a parent's failure to adequately protect the child from dangers in the physical environment. A recent

prospective study of injuries in infants and toddlers illustrates that the highest proportion of injuries occurred in high stress families, headed by single, unemployed mothers who smoke. Injuries tended to occur in the home, where supervision was frankly inadequate or at best questionable. (9)

At the very least, there is evidence to show that the consequences of maternal drug and alcohol use are not limited to the drug addicted infant. When considering proposals for dealing with the problem of maternal drug use, we must also consider the less apparent problems of potential physical abuse and injury from accidents due to the lack of adequate supervision. These women must be motivated to participate in drug rehabilitation programs as well as learning how to properly parent their child or the state must take measures to remove the child from the harmful environment.

Unless all infants are tested for prenatal drug exposure, we may never know the scope of this problem and we certainly will not be able to identify children at risk. Whether to indict and convict these mothers for exposing their child to drugs inutero is a difficult question to answer. If all mothers of drug exposed infants are prosecuted, our welfare system could not possibly accomodate the demand for foster placement of these children. Marion County presently has a waiting list of 59 to 77 children weekly. With only 300 foster families presently available, the alternative for most of these infants would be placement in group or residential homes.

A better alternative for both the mother and the infant would be a program of drug rehabilitation in conjunction with intensive parent

education. This cannot be accomplished in the usual postnatal hospitalization period of twenty-four to forty-eight hours. The ideal situation would be to transfer the infant from the acute care hospital to a subacute, transitional facility. Lifelines of Indianapolis is an example of such a facility, that provides a less intensive and more homelike atmosphere, where the parent can learn to interact with their child, while beginning their own drug rehabilitation program. Parent education can be geared to the individual's level of comprehension and support services can be initiated to better insure a safe transition home. The drug rehabilitation program should include peer counseling from recovered drug dependent mothers and should include parenting skills, development of self-esteem, job training and day care. The goal of such a program should be to remove the mother from the environment that initially lead to drug use. Such a program would require substantial federal and state funding, but the alternative is to pay for incarceration of the mother and lifetime foster placement for the child. A reprieve from indictment would be granted as long as the parent continued in the drug rehabilitation program and complied with the medical care follow-up specified for their child.

Inclusion of these children in the PL 99-457 program which directs the state to provide multidisciplinary intervention to disabled and at risk children from birth to five years of age would allow optimal therapy and intervention for the long term effects of prenatal drug exposure.

The costs to society to care for drug exposed infants, abused

children and catastrophic injuries related to parental drug use is staggering. In-patient hospital stays range from $500.00 to $1500.00 per day. Foster placement costs range from $8.50 to $25.00 per day. It seems that money spent in prevention of maternal drug and alcohol abuse during pregnancy and drug rehabilitation programs after delivery would not only be more cost effective, but also may spare children from future abuse and injury.

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Senator COATS. Thank you very much.

Mrs. Waggoner, we appreciate you being willing to come and give us your story, and we look forward to hearing you. If you will take that mike and pull it up very close to you, we will all be able to hear. Thank you.

STATEMENT OF HOLLY WAGGONER, PATIENT, INDIANAPOLIS, IN

Mrs. WAGGONER. OK.

Senator COATS. Tell us who you are, Holly.

Mrs. WAGGONER. My name is Holly Waggoner, and I am addicted to methadone. I am 28 years old, and I am expecting a baby.

Senator COATS. And how long have you been under methadone treatment now?

Mrs. WAGGONER. About 9 months.

Senator COATS. So you were using some substance prior to that, and is this your first pregnancy?

Mrs. WAGGONER. No, it isn't. This is my fourth pregnancy.

Senator COATS. Were there any complications from earlier pregnancies due to substance abuse or alcohol abuse?

Mrs. WAGGONER. Yes, there was. My last child was born under the influence of heroin and cocaine, and he was born 2 months prematurely. I ended up losing him because of the fact that there were no treatment programs for me to go to to seek out any help. There wasn't any residential treatment, there wasn't anybody who would take pregnant women on drugs or nobody had the training, and I ended up losing my son over that, although he was OK. He was premature and he is doing well today, but later on, you know, who knows? But if I would have had help, I think, you know, that things would have been different.

Senator COATS. Now, I am not quite sure I followed you. Your son previously born——

Mrs. WAGGONER. Yes.

Senator COATS [continuing]. You had not received any treatment?

Mrs. WAGGONER. No, I didn't, and I was afraid to get prenatal care.

Senator COATS. Why were you afraid to get prenatal care?

Mrs. WAGGONER. Because I thought that my addiction would be revealed and that I would be incarcerated for it.

Senator COATS. What led you to think that?

Mrs. Waggoner: People saying that, "Well, it's child abuse," and this and that, and it just scared me off, and I was so wrapped up in my drug usage. And I did look for help, though, and it wasn't available to me, and they did have a few places for me to go and although they had a waiting list for 6 months, by that time the child would have been born. Also there were places that if you had money you could go to, but I had no money.

Senator COATS. How did you identify or get into a program this time?

Mrs. WAGGONER. I got into the methadone treatment program. It took me about 2 months to get in there. I was not pregnant until after I was on methadone. I was using heroin before I started the methadone treatment, and I have been in the treatment program now about 9 months.

Senator COATS. So you got in this program right at the very beginning of your pregnancy?

Mrs. WAGGONER. No, it was before my pregnancy.

Senator COATS. Before your pregnancy?

Mrs. WAGGONER. Yes. And then I realized I was pregnant.

Senator COATS. I see. So you are fairly confident that you have been under some type of treatment now for the entire duration of the pregnancy?

Mrs. WAGGONER. Right, but it's not the actual treatment that I would really, really need if I were using coke or if I were using illicit drugs. I think that I would need more treatment than that. I think that I'd need more intense treatment.

Senator COATS. You think you would need more intense treatment if you were using cocaine instead of heroin?

Mrs. WAGGONER. If I were using any other kind of drug other than methadone, I would need more intense treatment. I would need another program, and there isn't one.

Senator COATS. But the methadone is used as a substitute to treat you for your previous heroin?

Mrs. WAGGONER. Yes.

Senator COATS. And how did you become aware of this particular program that you are in now?

Mrs. WAGGONER. I became aware of it just by, you know, inquiring, knowing what methadone is.

Senator COATS. And did someone refer you to this, or tell you about it and you went, and you said you waited 2 months until they put you on the program?

Mrs. WAGGONER. Yes.

Senator COATS. What prompted you, or what motivated you to want to get into a treatment program?

Mrs. WAGGONER. Wanting help, wanting to live right in society, get a good education, a good job.

Senator COATS. I might want to come back to you, Holly. Let me ask Dr. Brown and Miss Ruhmkorff some questions here.

Dr. Brown, you talked about identifying abusers. What, in your opinion, is the best way to secure identification of abusers? For instance, should hospitals routinely test women on admission? Of course, at that time it is considerably down the line. Should doctors perform tests? Should clinics with program clinics, for instance, do testing? How do we identify abusers early on so we can get them into programs?

Dr. BROWN. I think one of the major approaches we need to take is eliminating this fear of asking questions of patients. When we see patients, regardless of whether it be on personal practice or patients who are in various prenatal clinics, one of the keys to identification is to ask the patient appropriate questions. Obviously, many patients may not initially say that they are using drugs or have used drugs, but with some persistence it has been shown that women, because of this concern of what effect the drug may have had on the pregnancy, may indeed identify themselves. Obviously, that is an ideal plan.

In addition to that, I feel that if we know that we are in a high-risk area or the numbers bear that out, the 7 to 10 to 15 percent positive urine screenings, then the approach has to be to try to

identify the drug user as early as possible in that pregnancy or prior to pregnancy.

We have to work very closely with drug treatment centers that are ongoing in the city when they see a pregnant patient so that we hopefully will be able to have that patient referred into the appropriate channels so she can receive prenatal care.

Random screening in high-risk clinics or in large institutions like my own have certainly produced the necessary information on many occasions whereby we can channel the patient into some type of preventive treatment program.

Senator COATS. When you say "random screening," you mean in an intense questioning process? Is that how you define "random screening"?

Dr. BROWN. We are talking about screening patients, in many instances, through screening their urine.

Senator COATS. So you are talking about some testing?

Dr. BROWN. Right. Your index of suspicion. If there is an index of suspicion you have to have the ability to be able to screen certain patients. Hospitals, obviously, don't necessarily have the power to screen all patients all the time, and that may be something that we need to look into as well. It is a worldwide problem that crosses many lines, and certainly the number of patients in the high-risk or PRINS project or private practice may be there that we have already learned about as well. So we have to be able to have this index of suspicion, enough, at least, to address the issue of patients and give them the opportunity to identify themselves.

Senator COATS. I would like to ask both you and Ann this question: Once you have identified a patient, an abuser, a mother, a mother-to-be who is pregnant, and they are a user and you explain the situation to them, what percent, roughly, voluntarily submit for treatment or a change or modification of behavior that would satisfy you that they are making reasonable efforts to protect the fetus and what percent don't do that? Is there a rough breakdown? Do most of them say, "Gee, I am glad you told me that. I will make changes," or do most of them, the message doesn't get through?

I wrote down the quote from Michael Dorris. He said, "Most substance abusers cannot understand even simple warnings about the dangers of substance abuse during pregnancy." So I am trying to get a handle on what percent respond positively.

Dr. BROWN. I think that many pregnant women, including women who are addicted to various drugs, are probably more motivated during their pregnancy to discontinue the drug, or at least to decrease their use of the drug during that pregnancy than at any other time in their lives, and we have to try to capitalize on that.

As far as percentages are concerned, in patients that we identify—you know, as I have said, once we have identified patients through positive screenings, many of them still deny use of the drug. One of the difficulties is I think we have to encourage patients to seek prenatal care. We have to work with our four "elementarium" of personnel: the sociologists, psychiatrists, psychologists and all personnel that we have available to try to get this patient into the proper treatment programs. It's not going to be an easy job, obviously, but we have certainly seen that women who have been enrolled in programs have done a lot better than pa-

tients who have not enrolled in programs, and I can't really give you a number on the percentage of women that have been identified that seek providers, that go to treatment programs, but I do believe that patients need to know that those programs are available, and by knowing that those programs are available, I think those numbers will increase.

Senator COATS. Ms. Ruhmkorff.

Ms. RUHMKORFF. I have a couple of comments. I have no idea what the statistics would be on that. I do know that drug abusers typically have "state of denial" just like alcoholics have "state of denial" about the problem, and I doubt that with the true addict it will make much of a difference attempting to steer them toward a program. I do think, though, for your occasional drug abusers, your recreational drug abuser, women who may have used it in the first few months of their pregnancy, realize the dangers of it, I think you can motivate them, by getting into a program similar to what they have done in smoking and alcohol.

There has been a great program of education to get pregnant women away from cigarettes and alcohol during pregnancy, and I think they have had much success with them. I think education is the key, but I would not plan on it working for anyone who is addicted.

Senator COATS. That gets us back to the central question of the first panel, and that is what both Secretary Bennett and I—we don't know what the answer is, but: What do you do, then? What is our responsibility with that identified mother who is an abuser but either won't or can't take the steps necessary to protect herself and to protect the baby? What is society's responsibility at that point, or what is the doctor's responsibility, or a nurse's responsibility or a treatment-clinic person's responsibility? How big is the problem, and where do we go?

And you said what I think is very, very true, and that is that substance abuse masks reality. The people are escaping reality, that is why they are on drugs in the first place. So the reality of the danger to the baby may not become apparent at all. You may tell them that, and the influence of the substance tells them just the opposite, "Everything is OK. I am in a perfect state of mind. There is nothing to worry about. I needn't be concerned." So where do we then go with that group of people, however large it might be?

Dr. BROWN. That is the hardest group to touch, obviously. The real addict who has little concern for herself, little concern for the welfare of the baby. I think that there are enough people, enough abusers there that may not be as out of control to certainly make an impact on the number of babies that we see that we certainly can improve upon. Obviously, we are not saying that we are going to be able to take every patient and make her drug-free and make her pregnancy outcome a perfect outcome. But there are many, many patients that I believe we can identify. We can capitalize on their motivation to stop using drugs during their pregnancy to have an impact, and I think that that's been shown, and we have seen that.

If we can decrease the numbers, and certainly by opening up more treatment centers for pregnant women, the message will get

across that there is something available for me if I am a drug addict, something available that will, hopefully, improve my outcome, not only during my pregnancy, but in the future.

We have to follow through on the infants—we talked about the incidence of the sudden infant death syndrome—following through on these infants, making sure they are in an environment that we can, hopefully, save their lives as well. And so there many, many things that we can do as a society, as a Nation, to make a difference.

Senator COATS. Any further comments on that, Ms. Ruhmkorff.

Ms. RUHMKORFF. I wish I had the answer to that question.

Senator COATS. I do, too.

Ms. RUHMKORFF. Without an adequate number of drug rehabilitation programs at this point in time, a lot of people advocate prosecuting the women, even during pregnancy, when she has been found to be using drugs during the pregnancy. We don't offer much in alternatives, and unless we have programs in place that provide an alternative, I am hard pressed to say they should be prosecuted at that point. I think we need to educate them, and I think we need to try, and that is something that hasn't been done in a mass effort in this country yet.

Senator COATS. Mrs. Waggoner, any thoughts on this question? You have had first-hand experience with this now. What about the situation where people don't come to the conclusion that you have come to, that they are pregnant, they are damaging themselves and damaging their baby. What do we do in situations like that? How do we deal with that? Do we just say, "Well, nice try. We did everything we could, but, unfortunately, that's just a baby we won't be able to help, that is just a mother we won't be able to help because she is not willing to"? Do you have a suggestion as to what we ought to do?

Mrs. WAGGONER. I think those type of women should be sentenced to a drug program and if they leave the program they go to jail. I think she should be forced to get help.

Senator COATS. You think there should be some mandatory enrolling in a program?

Mrs. WAGGONER. Certainly, for the baby's sake.

Senator COATS. One last question. Dr. Brown and Ms. Ruhmkorff, you may want to comment on this, also. Are there critical points in the pregnancy when the abuse has more consequences than others? Are there critical points that you need to look out for in terms of the fetus development where that substance has a bigger impact on the uterus?

Dr. BROWN. I think it already has been testified to about the potential problems with alcohol and what effect it might have at any time during pregnancy, certainly the early periods of fetal development, and like alcohol, many substances like cocaine have deleterious effects at various stages of pregnancy. We have to be concerned about this newly identified fetal abnormality syndrome of the fetal limbs that we are not sure why it occurs when women use cocaine, but certainly it appears to be an effect, and it occurs early in pregnancy.

We have to remember that the fetal brain is in its process of development during the whole pregnancy, and if we are going to con-

stantly abuse the fetal brain in its growth, that that effect may occur at any time during the pregnancy. So just because the mother escapes damage during the first 3 months, we certainly have to try to encourage her to eliminate that drug, because we know that the fetal brain is still developing. We don't know what one exposure to a drug might be. For instance, if we are concerned about sudden rises in blood pressure to the extent that it causes a placental separation, maybe one encounter with a drug like cocaine, the use of it at a particular time could be that event.

So education, intervention, discussing the fact that the pregnancy is ongoing for a 9-month period and not just for a critical period of development is important. If a patient escapes an event the first time certainly explain it to her, that just because she escaped once doesn't mean that she can escape again from the process.

Senator COATS. So one abuse at any time during the pregnancy places mother and baby at extreme risk?

Dr. BROWN. I believe so.

Senator COATS. Ms. Ruhmkorff, do you agree with that?

Ms. RUHMKORFF. Yes.

Senator COATS. Thank you very much, Ms. Ruhmkorff and Dr. Brown and Mrs. Waggoner, thank you for your testimony, and we appreciate very much your coming before us.

We now call our third panel, which consists of Stephen Goldsmith, who is Prosecutor for Marion County, and Jeffrey Parness, Professor of Law, Northern Illinois University.

While our witnesses are getting seated, let me pass along some words of thanks. Principal Woody is the principal of this fine institution here. I don't know, Woody, if you are still here. I am looking around to see you. I want to thank Woody and the school here for allowing us the facilities to conduct this hearing. And I also want to thank the Indiana School of Medicine and the Indiana State Board of Health for their help in putting this program together and securing witnesses. I continue to thank all of you for your participation.

Our third panel, as I said, consists of Stephen Goldsmith, Marion County Prosecutor, and Professor Parness from Northern Illinois University.

Mr. Goldsmith, we will start with you and then Mr. Parness, and then we will open it up to questions. Thank you both for coming forward to testify.

STATEMENT OF STEPHEN GOLDSMITH, PROSECUTOR, MARION COUNTY, IN

Mr. GOLDSMITH. Thank you, Senator. Just briefly to summarize the testimony that I am submitting to your subcommittee, let me start by acknowledging that of all of the areas of drug enforcement this is one of the most difficult tasks as we weigh the relative rights and responsibilities of individuals, adults, young children, and fetuses. We don't have the answers either in this community or, I suggest, in many of the places nationally.

I am chairman of the National District Attorneys Association Committee on Drug Abuse. Nobody so far has come up with any clear answers as to what the results of the prosecutorial involve-

ment should be. Certainly, last week in Indianapolis, recognizing the major philosophical differences between the medical and legal communities, we set up a joint medical/legal panel, in fact, to see if there was any middle ground that might be arrived at in order to break the cycle of the substance-abuse and particularly the cocaine-abuse baby.

If one steps back, acknowledging that, there are a number of possible options, and I just want to make a couple of comments about the national involvement. If I could, I'd like to start with a brief anecdote. I was on a panel some years ago before several hundred judges and debating AIDS testing and other issues, and a number of people stood up and said that privacy rights prevent testing for AIDS, and then the commissioner of the New York State prison system stood up, and one of the judges said, "Do you test for AIDS in the prison system?" and the commissioner said, "No." And the judge said, "Why not?"

And he said, "Because if we did and we found out the results, we'd have to do something about it." And I think he was sincere in his response that the cost and significant disruptions from finding out those answers were more than anyone was willing to face. And I think to some extent that that is true with the substance-abused baby, and particularly the cocaine-abused baby.

In Indianapolis and Indiana we don't do any substantial amount of research testing, so nobody, as far as I know, in the State can quantify the amount or growing degree of the use or possession or sale of cocaine. We participate in the national efforts of which you are aware of the drug-abuse forecasting efforts, the DUF and others, and we have seen that for at-risk females, those who are arrested in our community, the cocaine usage rate in the last twelve months has gone from about 5 percent to close to 20 percent. So we have seen a tripling or a quadrupling of cocaine use, but we don't know what the cocaine use in the community at large is, and for those reasons I think all of my comments ought to be footnoted with the fact that anything that is tried ought to be tried on a limited basis and tailored with research and evaluated.

Across the country, Senator, as you know, prosecutors have occasionally resorted to the prosecution of mothers who were providing cocaine to their newborns, and that would be a relatively easy prosecutorial technique to accomplish. One would just have to work with the hospitals to set up a protocol to watch for withdrawal signs and, in isolated cases, prosecute the mother. There are plenty of laws available in Indiana to prosecute the mother, because, obviously, once the baby is born, even momentarily, the mother is delivering cocaine through the umbilical cord and can be charged with delivering a controlled substance. She could be charged with medical neglect and a number of other possible charges.

However, it seems to me that, although it may be worthwhile in demonstrating the message to the community, it misses the fact that in some large urban areas thousands and probably in this community hundreds of young babies are born with controlled substances in their blood that don't show signs of withdrawal and therefore are very difficult to diagnose by medical authorities. Therefore, Senator, I have submitted for your consideration two or

three different ideas in terms of national agenda and a local agenda as well.

I would submit—and I want to be careful about this, because in some of the advanced coverage in the transcripts released by the committee, there has been a little confusion on this. When a mother comes in for prenatal testing and blood or urine is taken as part of the medical workup, I think it is logical to test for controlled substances that are available in the community at large. So when a doctor or hospital goes in to test for blood sugar or syphilis or whatever else, they can do an additional test on that particular specimen.

I do not think that that information should necessarily be shared with law enforcement. I think it would be counterproductive, at least initially, to suggest that the sharing of cocaine data with law enforcement might very well deter marginally committed mothers in terms of prenatal care from receiving that care anyway. I think that to blind ourselves to the cocaine problem and not allow our doctors to provide the medical opportunity to intervene early on in the life of the child or fetus is a mistake and therefore I have advocated a more broad-based testing for cocaine as part of the testing procedure now. I think that ought to be the standard of care.

Then, Senator, at the point of delivery I think it is appropriate, after research showing the extent of drugs in our community, to test the baby for certain specific drugs, including cocaine, and if the newborn baby has cocaine in his or her blood, I think that the mother should be confronted with a possible charge at that time. Just briefly, if the baby had cocaine in her blood, then that event would be automatically reported under Indiana's current child-abuse reporting laws.

That would allow a number of possible interventions, some of which would be counterproductive: automatically taking the baby from the mother. Automatically doing that would be counterproductive, but having the State, in terms of prosecutors or child protective service workers use their club to force the mother to get treatment through the hospital or doctor and intensive pediatric involvement, I think, would be helpful.

And if I can use a brief example, Senator, we now, if a student is—hypothetically, we will pick this particular school—this is a particularly good school in terms of attendance——

Senator COATS. We hope it's a drug-free school, too.

Mr. GOLDSMITH. This is a drug-free school in terms of attendance, but as far as this township is concerned, we have a program in this township and other townships that if the school social worker or home/school counsellors are having difficulty in getting parents to bring their child to grade school or junior high child to school, or to class, we will notify the parent. If they don't cooperate with school authorities to get the child to school, we will prosecute them for educational neglect. I think the same could be true of a child born with cocaine in his or her blood, notification of the Child Protective Service, notification from the prosecutor's office, if you will, to say, "You work out an agreement with the hospital and pediatrician, you stay off drugs. You will be tested for drugs, you take your child for pediatric involvement, and therefore we will save the child."

We also know, as the Senator knows, that it's not just a matter of furnishing cocaine to the baby, that there is a 25-to-40 percent chance that the mother is using cocaine and there is cocaine in the family and there is a 25-to-40 percent chance that the child will also receive physical or sexual abuse in the home after the discharge from the hospital.

So I think that there ought to be testing after the birth and that testing, if there shows positive tests for drugs, law enforcement should be notified.

The final subject, Senator, slightly afield from prosecution but related to it in a way, is what to do once you find a positive test. Even those of us in law enforcement are not under the impression that simple prosecution and incarceration is going to solve the cocaine problem with respect to moms. And two things naturally could be evaluated: (a) we run a child-support office in this county under contract to the Federal Government, and (b) mothers are eligible to come in for our services after the birth of their children.

They have, nationally, the option of the State starting its child support and AFDC eligibility earlier, even at the point of conception, I would submit, and if we backed up AFDC eligibility and child support enforcement to the point of conception and therefore the mother who saw a doctor for prenatal care will become eligible for AFDC payment, I would submit—and obviously I am not a fiscal expert—that the net cost to the country would be substantially less than the costs we are now having from birth defects and damaged children as a result of lack of prenatal care and therefore if we extended AFDC back to the point of conception nationally, we would encourage mothers to come forward for prenatal care, and they then would have the intervention before the low birth weight, birth defects issue happened.

Finally, Senator, the issue that troubles us all, regardless of our philosophical differences of opinion and regardless of our views on what the constitution allows and doesn't, is essentially the absence of treatment facilities nationally and locally. Even once we find out this problem, how do we intervene? And I would think it prudent if the Congress would investigate taking the SOBRA medical benefit program and extending it to include drug treatment pre- and post-delivery for a mother who is involved in substances. It makes very little sense for us to say, "We will give you medical benefits, but if you deliver a baby on drugs those benefits terminate," and to extend the SOBRA benefits to include drug testing and to extend the AFDC back to the point of conception, would give the fetus child an opportunity for a full life, which he or she does not have today.

So therefore, Senator, I am stepping through this carefully in Indianapolis with this medical/legal expert panel. I understand the constitutional issues are significant. But I think by not testing and not treating and not encouraging the treatment, and even, if you will, not forcing the treatment, we are allowing a generation of babies and young people with defects and not giving young people a fair start. And regardless of what persons say the constitutional rights of the mother are, I don't think her constitutional rights are to either deliver cocaine to her child or to purposely allow a birth defect to a child to be born, and I appreciate the Senator's interest

in the significant problem, and, obviously, take a local and a national response, and I believe today's hearing will help set a standard in that area.

[The prepared statement of Mr. Goldsmith follows:]

PREPARED STATEMENT OF STEPHEN GOLDSMITH

I. INTRODUCTION

The purpose of this testimony is to summarize the vantage point of a District Attorney to the issue of substance abused babies. This brief testimony does not purport to summarize existing research or to evaluate the long-term medical or societal problems that have and will result from this crisis. Rather, what is presented below summarizes proposals that will be studied in this city and ways in which the U.S. Government could help.

I have previously served as the only District Attorney appointed to the Attorney General's Advisory Board on Missing and Exploited Children and currently am chairman of a joint task force on drug-affected babies set up by the National Center for the Prosecution of Child Abuse and the Center for Local Prosecution of Drug Offenses. The comments which follow will be submitted to that joint task force for discussion.

II. THE INDIANAPOLIS PROBLEM

There is no good survey of cocaine use generally in Indiana. Locally we participate in national Drug Use Forecasting (DUF) and in comprehensive testing of all juveniles arrested and detained. These tests are of a particularly at-risk population, but nevertheless show an explosion of cocaine use among females of over 100% this year alone.

Although not increasing, marijuana and alcohol abuse reach a much larger percentage of women in this community. Hospitals and clinics now fail to test for cocaine, therefore good data upon which to make an informed opinion does not exist. However, based on the greatly elevated cocaine use rates, and the increased number of child abuse reports referring to drugs in the household, and hospital test results from other communities, one can safely conclude that the problem of substance abused babies is a most serious one for this city and state.

III. WORKING TOWARDS AN ANSWER: PUNISHMENT AND TREATMENT NEED NOT BE MUTUALLY EXCLUSIVE CHOICES

A. RANGE OF PROSECUTORIAL CHOICES

An Indiana prosecutor has several choices. Evidence of a controlled substance in the child's or mother's blood system might be adequate proof of possession by the mother, allowing for prosecution.

A positive test on the baby could lead to a charge of delivering a controlled substance because it is inevitable that the drugs were delivered through the umbilical cord momentarily after birth. A mother who is nursing and on cocaine will also be delivering the substance to the baby. A charge of Neglect of a Dependent might also be possible.

Additionally, the prosecutor or the welfare department could bring a Child in Need of Services (CHINS) petition based on the addiction of the child.

Finally Indiana might consider passing laws making the use of drugs illegal or extending more protection to the fetus. In Indiana today the only law that would clearly protect the fetus makes it a crime to kill a fetus. Indiana, of course, could add other crimes. This state was one of the first to pass a law making it illegal to drive with a controlled substance in the blood stream. We did this while I was Chairman of the Governor's Task Force Against Drunk Driving. This per se law (it is illegal per se, the amount is irrelevant as is the impairment) would serve as a model for possible legislation concerning drug use during pregnancy.

B. A PROPOSAL FOR A COMPREHENSIVE RESPONSE

The purpose of a legislative and programmatic response should be to increase the chances that the mother will reduce or eliminate her drug use as early as possible. The question then becomes whether prosecutor involvement is constructive. With the enormous number of drug babies existing now nationally one could easily claim that it is difficult to see how our involvement could make the situation worse.

However, a more thorough response indicates a possible middle ground. A joint medical/legal task force in Indianapolis is investigating a wide range of responses. Isolated prosecutions of mothers whose children are addicted might be appropriate, but so long as relatively limited in number, they will have little effect. Undervalued in the national dialogue is the effect of a well-publicized prosecution in emphasizing to the public generally (the casual user) the wrongfulness of the conduct. Those who argue against prosecution essentially argue for decriminalizing drug dealing to infants, which obviously sends the wrong message.

1. Hospital and Medical Response

Prenatal and pre-delivery urine tests must include, for medical purposes, a test for cocaine. A high-level medical advisory group should accumulate information and publish findings that would force the medical standard of care to include such tests. If current testing looks to elevated blood sugar, or syphilis, are not the risk factors of cocaine in some areas substantially higher?

The threshold question then is not to make the medical community agents of the state but to emphasize that if for example, placental abruption, still births, hemorrhages, brain damage, infarctions and birth defects are caused by prenatal cocaine use, then testing for purposes of medical diagnoses should be a requirement.

If the medical community is unwilling to approach the solution in this manner, then cities, states, or the federal government should consider mandated testing of newborns.

Similarly, the postnatal effects of cocaine may be less clear but research reflects problems with infant motor skills and spatial orientation, and other difficulties. Testing should occur of the baby and the mother at birth for purposes of pediatric involvement. Mothers who breastfeed should be dissuaded from using cocaine and should be tested for monitoring.

In Indiana the positive test at delivery of the child and perhaps the mother require notification to the Department of Public Welfare under mandatory child abuse reporting laws. Such a report would not be different in type than other abuse reports now made by hospitals based on lesser levels of evidence to suspect a parent of abuse.

2. The Child Protective Service or Prosecutor Response

A prosecutor learning of cocaine abuse at birth would have a range of possible responses, the two most likely of which would be a CHINS petition (which welfare also could do) or a medical neglect charge.

I recommend evaluation of a combined approach with the hospital pediatrician and the prosecutor. Under this approach, a positive maternal cocaine test would lead to an agreement between the state, the mother, and the medical provider. It would provide for a medical regimen (i.e. a discharge agreement) which would require treatment and urine tests over a period of time plus increased pediatric involvement. The prosecutor would agree to withhold charges if the mother successfully completes the terms of the agreement.

A model for this approach exists in this city in the area of educational neglect and truancy. At the request of the schools we send letters to parents of grade school children who are regularly absent telling the parents to reach an accord with the school

counsellors, or we will prosecute for educational neglect. This procedure has been effective.

C. NECESSARY RESPONSES AND THE PROBLEMS

1. Prenatal Care

a. Testing

A critical goal is to pursue a prosecution/medical model that encourages and not discourages treatment. Such a result is more probably accomplished postnatally. Prenatal care should require cocaine testing for purposes of medical attention. The positive results would not necessarily need to be reported (at least during a research and evaluation period)

If a mother tested positive early in her pregnancy then treatment and intensive counselling could occur. Indeed, a district attorney could establish a policy for post-delivery prosecutions that provides a benefit to those who have sought prenatal care. Prosecutions or agreements with mothers concerning medical neglect or delivery of cocaine to the infant could lead to reduced charges or sentences or conditions for the mother who obtained prenatal care. Thus the prosecutor in a refined policy could encourage prenatal testing through subsequent lesser prosecution.

b. AFDC

Similarly, we need to address the larger question of access to and availability of prenatal care. The Senate should evaluate the possibility of moving mandated AFDC eligibility back to the point in time when a doctor determines that a pregnancy exists. Such a decision would encourage mothers to receive medical attention and would allow for a range of services and interventions that do not now occur.

The obvious question is one of cost. However, the costs associated with birth defects, low birth weight babies and other related problems are enormous and when evaluated might even exceed the relatively minimal costs of an additional 7-9 months of AFDC eligibility.

Additionally, I spend considerable time involved in the national effort to collect child support. Fathers should be responsible from the point of conception for the care of the children, and some of the costs would be offset by child support collection and the early intervention with the father would not only yield short term collections, but would improve long-term collections through increased paternity establishments and knowledge of the location of the father. Also an earlier enforcement strategy would force the

father to pay attention to the consequences his actions and the possible consequences of the mothers cocaine use.

Finally, the fetus deserves at least that much protection from our society from this early intervention.

2. Treatment

The most significant problem that exists is the absence of adequate treatment and the pronounced absence of evaluations of successful treatment strategy. Treatment, which would be a condition of an enforced agreement by a prosecutor must be available. In this community where the state invests little in drug treatment, assistance for poorer families is barely available, and then only after long waits.

The SOBRA medical benefits should be expanded to include post-delivery substance abuse treatment when the mother tests positive for drugs. There is considerable confusion in Indiana whether such coverage is available under current law, with the general opinion that it is not. To turn the cocaine-using mother and child back out into their community with no treatment resources not only harms the child but inevitably increases the costs to society.

IV. CONCLUSION

There is nothing inconsistent with punishment and treatment. The research that our Task Force Against Drunk Driving heard presented in testimony clearly reflected that successful alcohol intervention was as likely to succeed if the person were forced to counselling by the justice system as if he entered on his own. Therefore the club of prosecution should be used to force treatment.

However, the government should place significant resources into the evaluation of medical and justice responses, as well as funding for indigent treatment. Practitioners have little guidance as to which models and which treatments are successful. The marketing and sales strength of a treatment organization should not necessarily be the best indicator of their efficacy.

Similarly experiments using different models need to be funded to determine which actions cause the greatest maternal response prenatally and most successful response postnatally.

The issues involved are very complicated with conflicting rights and responsibilities. Nevertheless the possibility certainly exists for a coordinated response.

Senator COATS. Thank you very much. Mr. Parness.

STATEMENT OF JEFFREY PARNESS, PROFESSOR OF LAW, NORTHERN ILLINOIS UNIVERSITY, CHICAGO, IL

Mr. PARNESS. Thank you, Senator. Before I begin to summarize my prepared remarks, I would like to say I heartily agree with much of what Mr. Goldsmith has said, and I'd ask him and you and others perhaps to consider not only moving eligibility for AFDC back to conception, but moving the whole range of laws with respect to parental responsibility, whether we are talking about a pregnant woman or an expectant father, or if we are talking about someone who is in need of government assistance, now to move back all prospective parents' responsibilities with respect to their future children to the point of conception. It seems to me there is some legal movement going in that direction, and it seems to me we ought to go further with that kind of development.

I would like to spend a few minutes talking about the possible use of coercive laws, particularly vis-a-vis pregnant women with respect to this problem. I think there is a general agreement that noncoercive, voluntary laws to protect the unborn should be continually expanded, while laws involving access to rehabilitation programs for pregnant women, support money for medical care for indigent pregnant women, educational programs with respect to promoting life with respect to newborns should be promulgated.

There is significant disagreement, however, and I think much misunderstanding of the ways in which the laws can coerce conduct promoting live and healthy births, and I believe new coercive laws involving maternal alcohol and drug abuse are necessary, because I do not believe noncoercive, voluntary laws act to protect the unborn and can do so in the future, because I believe such laws can be written so as to respect constitutionally protected rights, because I think such laws would promote legitimate social concerns and do more harm than good.

Before reviewing briefly the form which such coercive laws may take, I would like to make the following preliminary points, particularly given to misunderstanding, I think, of the possible parameters of legal development.

Point 1, the decision in ROE v. WADE presents no significant obstacles toward coercing certain forms of conduct in the prevention of life-threatening, life-impairing as opposed to serving certain interests that the State government may pursue, an important and legitimate interest that is recognized in the Supreme Court in its decision in ROE v. WADE. It does seem to me that potential human life can be protected by laws within such diverse legal areas as torts, crimes and child custody.

There are two different ways, it seems to me, within the confines of ROE, to protect a potential human life by equating the born with the unborn, and we have some States who move in that direction, for example, will require a parent to provide care and sustenance not only to the living child but to a developing fetus. At times, however, the equation is not there, and you have States, for example, in a number of instances differentiating between homicide, which is the intentional killing of a human being, and feticide,

which involves the intentional killing of an unborn potential human being.

Point 2, the decision in ROE does mandate the law protecting the unborn which infringes upon the constitutional protective rights it was founded on the common State interests. There is no dispute about that. It seems to me when we talk about laws with respect to maternal drug or alcohol abuse, we may be talking not only about the constitutional protections recognized in ROE but the constitutional protection of childbegetting, childrearing and bodily autonomy and bodily integrity. Protecting such constitutional rights can only operate in situations in which the dependent is injured.

Because of that, Point No. 3 would be the concerns for these constitutionally protected rights have forced most coercive laws for the protection of the unborn to operate for others than for pregnant women. Pregnant women typically have their constitutional interests involved with respect to coercive State conduct.

I would note to you in the last few years there has been very significant development, growth, if you will, in the number of coercive laws that are employed to protect potential human life that operate on those other than pregnant women. For example, development in Minnesota, North Dakota, Washington, Illinois with respect to crimes against the unborn by those other than the mother are for medical attendees. There has been development in the tort law here, not only in terms of protection of viable or pre-viable fetuses, but in a number of jurisdictions of the ability to sue even for what is referred to as preconception a harmful activity to those now living for conduct prior to their conception.

Finally, in a recent decision in Florida, the Supreme Court there ruled that a man who fails to support his unborn child's mother can have that failure utilized by the State in a parental termination proceeding, once gaining recognition of the need and of the government to protect a potential human life and operating outside the confines of maternal conduct.

With those general points in mind, let me review with you some coercive laws involving pregnant women that might be utilized to protect their unborn children. The most controversial force that these laws have that address the behavior of women operate regardless of their wishes. Such laws often impact on constitutionally protected rights, but in that instance, at least, there needs to be demonstrated a compelling State interest.

Laws involving substance abuse by pregnant women exemplify the controversy, and I compliment Mr. Goldsmith on his passion for protection. I would consider three possible scenarios: (1) Laws permitting substance abuse during pregnancy to be the basis for criminal prosecution after treatment has been refused for neglect of the unborn child. (2) Laws involving substance abuse by pregnant women to be the basis for terminating parental rights to the later-born child. And, (3) laws with respect to substance abuse by pregnant women as providing the foundation for an injunction restricting the activities of a pregnant woman during her pregnancy, perhaps even including an order of confinement in order to protect the potential human life.

I think child-abuse prosecutions which protect the child before it is born are available at this point in time, at least in some jurisdic-

tions in the United States. For example, in California, a provision of the penal code defines as a misdemeanor a parent's willful omission to furnish necessary medical attendance or other remedial care for his or her child and goes on to characterize the children protected as those who are conceived but not yet born. It seems to me that provision could be applied in some settings without infringement upon any constitutionally protected right, and I think it is unfortunate that attempts to prosecute adults and the attempt to use that against Pamela Stewart failed of prosecution, I think, casts a cloud on the statute's future utility. But it seems to me those kinds of statutes would need to be further examined.

With respect to a civil court proceeding, it seems to me that a child custody law with respect to termination of parental rights at birth for prebirth conduct are available and lawmakers, both in State legislatures and United States courts are increasingly concerning themselves with respect to extreme conduct by potential parents in determinations as to whether or not those parents, upon the birth of their children, would be temporarily confined or to have their parental interests terminated permanently.

Comparably, as well, there has been increasing interest recently in developing the legal means by which harm to the unborn can be prevented rather than simply acted upon after the fact. There have been a number of different courts in the past few years that have entered orders dictating that women found to be involved illegally with controlled substances be cooperative with health officials in order to protect potential human life. Those orders have been issued by a variety of forms of courts.

Obviously, the biggest problem is when those courts are criminal courts, and the problem is in sentencing. The more successful ones have been juvenile courts or probate courts or family courts, and it does seem to me that those kinds of civil court orders, in particular, ought to be considered more serious. It does seem to me there are instances in which those kinds of coercive acts by civil courts are legitimate and given to social protection of human life, notwithstanding constitutionally protected interests of those against whom they operate. Particularly in instances, I think, where the conduct at which the injunction is directed is itself illegal, it seems to me legally justifies coercive action.

I would urge caution with respect to State coercive action. Problems do arise in trying to determine what kinds of conduct create an unacceptable risk of a potential human life. Medically acceptable risks sometimes are wrong, and certainly there is legitimate reason to be concerned about the chilling effect of these laws on potential parents and others. Nonetheless, while caution is needed, it does seem to me that some of the practical difficulties and dangers can be accommodated for carefully drawn laws and rulings.

There is no question at all about the relationship between certain kinds of conduct and harm to the unborn. I think governments can look to intervene only in situations where medical and other assessments of risk are beyond dispute and where the dangers posed are significant.

And, finally, it seems to me silly to fail to recognize—as was recognized by the Supreme Court in ROE v. WADE—the important and

legitimate interest in protecting human life and thus the State's special interest in certain decisions made by pregnant women.

Those laws regarding a prospective father's legal obligation to his unborn child, as well as tort and criminal laws protective of the unborn from hostile acts by strangers, suggest that State efforts on behalf of the unborn are not sexually discriminatory and often ultimately inure to the benefit of women seeking the birth of live and healthy children.

Notwithstanding the difficulties of constitutional interpretation, of line-drawing and balancing, and of guiding and dictating social behavior through laws, coercive legal action protective of the unborn from the dangers posed by mom and others is on the rise and should continue to be seriously considered. Thank you.

[The prepared statement of Mr. Parness follows:]

PREPARED STATEMENT OF JEFFREY A. PARNESS

Pain ensues when one learns that a newborn has mental or physical disabilities which will inevitably result in either an early death or an impairment in the ability to live a whole and healthy life. It is especially painful to learn that such disabilities were fully, or substantially, preventable. Anger develops, fingers are pointed, fault is ascertained, prevention hereinafter is promised, action is taken. To seek to assure that more humans are born with a sound mind and body seems as American as apple pie. Governmental efforts in the enterprise do not appear inappropriate. What, if anything, may governments generally do to limit such disabilities? What non-financial constraints, if any, operate on governments choosing to undertake such a noble mission? And finally, as more is known about the causes of and cures for disabilities at birth, what in fact have governments been doing? This statement briefly addresses these questions.

It will be urged that the widespread sentiment that the U.S. Supreme court's decision in Roe v. Wade[1] bars significant governmental protection of the unborn is misguided; that the court's ruling in fact, recognizes opportunities for major legislative efforts whether or not the unborn are characterized as persons; and that in the years since Roe v. Wade, there have actually been noteworthy state legal efforts protective of unborn human life. It will be recognized that laws protective of the unborn which operate coercively on women of childbearing capacity (and on prospective fathers) require close scrutiny as constitutional interests may be present. Nevertheless, it will be suggested that at least some laws regulating prospective mothers' (and fathers') conduct in order to protect their future offspring are both constitutionally sustainable and socially desirable.

I.

The prevention of life-threatening and life-impairing disabilities in newborns is certainly an interest which may be pursued by governments. Because such a pursuit typically involves the state in conduct preceding the birth of those to be protected, many have characterized such a pursuit as involving the protection of potential human life. The United States Supreme Court, in its decision in Roe v. Wade, expressly recognized and approved a state government's "important and legitimate interest in protecting the potentiality of human life."[2] Seemingly, potential human life is protected through laws promoting live and healthy births, whereas human life is protected through laws promoting the continuing live and healthy condition of those who walk the earth today. Potential human life is now protected by laws within such diverse legal areas as torts, crimes and child custody.

On occasion, lawmakers will seek to protect potential human life by equating the human unborn with those born, creating a setting where all the possible people of tomorrow are protected by the people of today. For example, under one law an already-born child and a developing fetus have each been deemed possible victims of parental abuse and neglect.[3] And, under some

court decisions both a pregnant woman and her unborn child have been comparably deemed patients of certain doctors.[4] On other occasions, lawmakers will protect potential human life though clearly rejecting any equation involving the born and the unborn. For example, certain states have both homicide and feticide laws within their criminal codes.[5]

The protection of potential human life can be significantly promoted through most types of law (civil, criminal and regulatory) and by many types of lawmakers (legislatures, courts, and administrative agencies). Certain protections are most appropriate for state governments (criminal, tort and child custody laws), while others seem best undertaken at the national level (laws helping to finance good prenatal care). Laws protective of potential human life can serve the unborn exclusively, or can promote simultaneously other interests, such as maternal health. At times, the protection of potential human life is only an unintended consequence of a law chiefly serving some other purpose.

Laws can protect potential human life in a variety of ways. Laws can make money, food, medical care, and the like available to pregnant women, or to fertile men or women, who choose to undertake conduct directly beneficial to their unborn children, or who choose to avoid conduct which is likely to be harmful to their future offspring. And laws can help to educate future parents and others regarding the means by which they can assist in promoting live births and in preventing birth disabilities. Laws can also protect potential human life in more coercive ways. Tort claims or criminal prosecutions for acts already harmful to some unborn will deter similar conduct in the future. Beyond such general deterrence, coercive legal action may also seek to prevent foreseeable harm to some particular unborn by enjoining the conduct of those involved in, or having an impact upon, the relevant child-bearing process. Extreme cases may involve the imposition of certain conditions on a pregnant woman.

II.

In acting to protect potential human life, the traditional non-financial constraints on governmental power operate. Laws must be neither arbitrary nor capricious; some legitimate governmental goal must be at stake. Typically, this means laws protective of the unborn must be based on acceptable views of the causal connection between the conduct regulated and the chances for live and healthy birth. As well, the effectiveness of the law in promoting the desired conduct must be shown. Unlike many other police power analyses, however, there are often further limits on exercises of governmental power protective of potential human life. This is because such exercises often raise concerns about the infringement of constitutionally-protected rights. The decision in Roe v. Wade is illustrative.

At issue in Roe was a statutory scheme which effectively prohibited most pregnant women from procuring abortions. The prohibitions thus protected potential human life, serving a state interest which the Court found to be "important and legitimate."[6] Yet, the scheme also restricted a woman's right to decide to terminate her pregnancy. Because a woman's right to choose was found within the constitutionally-protected right to privacy, and because the

state's interest in all fetuses was not "compelling"[7] (though legitimate), the scheme was invalidated. The Court did observe that the state had a compelling interest in protecting the potential life of all viable fetuses, so that third-trimester abortions generally could be outlawed.[8]

While Roe v. Wade concerned the constitutional right involving pregnancy termination, the Court's decision suggests a "compelling state interest"[9] will be necessary to sustain any law protecting potential life which unduly infringes upon a constitutionally-protected right of any born person. Other rights of the unborn possibly implicated in potential life settings include decisional rights regarding childbegetting, childrearing, and bodily autonomy, and bodily integrity.

III.

Because governments are much freer to act where no constitutionally-protected rights are implicated, and because pregnant (as well as fertile) women often can assert such rights with respect to laws protecting their future offspring, most laws protecting potential life human involve non-maternal conduct. Where the conduct of prospective mothers is addressed, laws protective of potential life are usually welcomed by would-be mothers as these women typically join the state in seeking protection for their future offspring. In only certain limited circumstances will a state determine it is necessary to compel a woman's conduct against her wishes in order to benefit her future offspring. When such a compulsion constitutes a burden on any of the woman's constitutional rights, the rationale(s) prompting governmental action must, of course, be compelling.

In the last few years, there has been a significant growth in American laws protective of potential human life. An examination of some of these developments reveals the variations in the types of laws and lawmakers now concerned with promoting the birth of healthy infants.

A major development in the regulation of non-maternal activities protective of the unborn is the adoption of criminal laws characterizing the unborn as victims. Early in 1986, the Minnesota legislature created a distinct statutory scheme providing broad criminal law protection of the unborn.[10] The scheme encompasses various forms of culpable activity causing injury to the unborn (premeditated, intentional, grossly negligent, and negligent acts) and varying forms of injury to the unborn (acts causing the termination of a fetus' potential life as well as acts causing injuries appearing at birth). Later that year the Illinois legislature enacted a similar statutory scheme, with the unborn deemed the possible victims of such crimes as intentional homicide, voluntary manslaughter, involuntary manslaughter, reckless homicide, battery, and aggravated battery.[11] In 1987, the North Dakota legislature added several criminal offenses committed against unborn children, including murder, manslaughter, negligent homicide, aggravated assault and assault.[12] Since then, the Washington state legislature has redefined the crime of assault in the second degree to include acts harming an unborn quick child.[13] Of course, alterations of criminal laws may also influence in significant ways existing and related civil laws.

Another major development in the regulation of non-maternal activities protective of the unborn involves the expansion of tort law so as to permit claims on behalf of those who allege their disabilities at birth were caused by the pre-birth misconduct of doctors or others. In many states, claimants may include those who were in the previability stage of fetal development at the time of the alleged misconduct.[14] Since 1977, a number of states have further expanded tort law so as to permit civil actions by claimants who were not even conceived at the time of the defending party's alleged misconduct.[15]

There is often little controversy where laws address the conduct of prospective parents in order to protect the potential life of their future offspring. Consider, for example, laws providing for better prenatal care (nutritional food supplements to low-income pregnant women); for treatment of drug or alcohol abuse on a voluntary basis; for warnings on the labels of products known to cause disabilities at birth; and for financial support of medical treatment leading to childbirth. Such laws are relatively non-controversial because they are non-coercive.

Most controversial of all laws protective of potential human life are those which address the behavior of potential parents-especially pregnant women- and which operate regardless of the wishes of those whose behavior is at issue. As noted earlier, such laws often impact upon constitutionally-protected rights; when they do, they can only be sustained if there is demonstrated a compelling state interest. As well, it is often difficult to predict (or even describe) the consequences of such laws in advance of (or even after) their implementation. Thus, such laws may involve some speculation about human conduct and necessitate continuing re-examination after implementation.

Laws involving substance abuse by pregnant women exemplify the controversy. Consider laws permitting substance abuse during pregnancy to serve as the basis for

1. a criminal prosecution for abuse or neglect of an unborn child;

2. an order terminating parental rights respecting the later-born child; and/or

3. an injunction restricting the activities of a pregnant woman, including an order of confinement.

Criminal child abuse prosecutions of women who took certain drugs or alcohol during pregnancy may now be permitted in at least some parts of the United States. In California, a provision of the penal code defines as a misdemeanor a parent's wilful omission, without legal excuse, to furnish necessary medical attendance or other remedial care for his or her child, and thereafter deems a child conceived but not yet born as an existing person within the provision.[16] The provision seemingly can be applied in at least some settings with no infringement upon any constitutionally-protected right, and it clearly promotes what the court in Roe called the "important and legitimate interest in protecting the potentiality of human life."[17] The much-publicized trial court dismissal of child abuse charges against Pamela

Rae Stewart in 1986 (while pregnant, she ignored a doctor's advice, including admonitions about taking drugs) casts a cloud on the statute's future utility.[18]

A simple hypothetical case serves to illustrate the possibilities for civil court involvement in terminating parental rights for pre-birth conduct and in restricting the activities of pregnant women in order to protect potential human life. Consider a case involving a prospective mother whose conduct is found by a trial court to be causing significant harm to a developing fetus. May there ever be a sufficient cause in pre-birth conduct for the court to terminate at birth the woman's interest in the later-born child? And, assuming a constitutionally-protected interest is implicated, may there ever be a sufficiently compelling state interest (especially in conduct which is non-criminal) to legitimate an injunction restricting the activities of the woman during the pregnancy so as to protect potential human life (perhaps via a guardian appointed on behalf of the fetus)?

Courts and legislatures involved in child custody laws are increasingly concerned with the prebirth conduct of prospective parents. Lawmakers with and without black robes have recently determined that a drug-exposed infant can be found to have been abused (or neglected) by a mother who illegally took a controlled substance during pregnancy.[19] Just a few months ago the Florida Supreme Court ruled that a man who fails to support his unborn child's mother prior to birth loses his standing in (and thus his need to give his consent to) an adoption proceeding involving his later-born child. Specifically, the court stated: "Because prenatal care of the pregnant mother and unborn child is critical to the well-being of the child and of society, the biological father, wed or unwed, has a responsibility to provide support during the pre-birth period."[20]

Comparably there has been increasing interest recently in developing the legal means by which harm to the unborn can be prevented. A number of different courts in the last few years have entered orders dictating that women found to be involved illegally with controlled substances, or to be acting dangerously otherwise, must cooperate with health officials in order to protect potential human life. Such orders have been issued by courts with diverse authority, including those with jurisdiction over family, juvenile, and criminal matters. While such orders involving potential life protection via the imposition of restrictions on pregnant (and non-pregnant) women by criminal courts during sentencing have met with difficulty, civil court orders against women seeking to deter future harm to their unborn have met with more success.[21] Can orders protecting potential life be entered against women even when maternal conduct is not criminal, though harmful to potential human life? For instance, consider instances of significant alcoholic consumption during pregnancy. In a case in 1983, a court was asked to assume custody over a pre-viable fetus and to order the pregnant woman to undergo a "purse string" operation so that the cervix would better hold the pregnancy. In declining to issue an order in the case before it, the Supreme Judicial Court of Massachusetts said: "We do not decide whether, in some situations, there would be justification for ordering a wife to submit to medical treatment in order to assist carrying a child to term. Perhaps, the State's interest, in some cases, might be sufficiently compelling. . . to justify such a

restriction on a person's constitutional right of privacy."[22] As with certain forms of medical treatment, may not a state on occasion have a compelling interest in prohibiting or limiting alcohol or drug consumption?[23]

As noted earlier, it is often difficult to predict the impact or to assess the consequences of laws mandating behavior by potential parents for the purpose of protecting their future offspring. Regarding state intervention, there are a number of practical difficulties. First, problems arise in trying to determine what types of conduct create an unacceptable risk for potential human life. Second, medical assessments of risk are sometimes wrong. Third, imposing legal obligations in order to protect the fetus may have a chilling effect upon potential parents and others. For example, it may be reasonable to anticipate that some women would not seek needed prenatal care or disclose important information to their medical attendants if they feared coercive state action. Finally, there is great danger in overriding a competent woman's (or any person's) decision about treatment of her body.

Undoubtedly, caution is needed in developing laws protective of the unborn yet coercive toward the mother. Practical difficulties and dangers can be accommodated with carefully-drawn laws and rulings. There is no question today about the relationship between certain forms of conduct and harm to the unborn. Governments should intervene only where medical and other assessments of risk are beyond dispute and where the dangers posed are significant. While the chilling effect of laws on women needing prenatal care or in a doctor-patient relationship must always be considered, many laws protective of the unborn are warranted by the existence of weightier countervailing governmental interests. As well, the nature and degree of any chill should not be overestimated. Preexisting laws may already trigger a significant chill so that the effect of new laws may be minimal. Consider, for example, the implications of existing child abuse reporting laws which cover drug-exposed newborns. Finally, it seems silly to fail to recognize--as was recognized by the Supreme Court in Roe--the important and legitimate interest in protecting the potentiality of human life, and thus the state's special interest in certain decisions made by pregnant women. Laws regarding a prospective father's legal obligation to his unborn child, as well as tort and criminal laws protective of the unborn from hostile acts by strangers, suggest that state efforts on behalf of the unborn are not sexually discriminatory and often ultimately inure to the benefit of women seeking the birth of live and healthy children.

Notwithstanding the difficulties of constitutional interpretation, of line-drawing and balancing, and of guiding and dictating social behavior through laws, coercive legal action protective of the unborn from the dangers posed by mom and others is on the rise. Apparently deemed inadequate on their own are voluntary governmental programs involving prenatal care, educational advancement, drug treatment, and the like. Such programs are inadequate both because necessary funding simply cannot be found and because significant numbers of people continue to act, whether intentionally or not, in ways harmful to the unborn even where such governmental programs are available. The tragedies of premature infant deaths and preventable birth disabilities are hard to forget or to forget about. These tragedies will, and should continue to, be addressed by carefully-drawn laws whose consequences must be subject to constant reexamination.

1. 410 U.S. 113 (1973).

2. 410 U.S. at 162.

3. Cal. Penal Code § 270 (West 1988) ("If a parent of a minor child wilfully omits, without lawful excuse, to furnish necessary clothing, food, shelter or medical attendance, or other remedial care for his or her child, he or she is guilty of a misdemeanor . . . A child conceived but not yet born is to be deemed an existing person insofar as this section is concerned.")

4. While most state courts allow children to sue their mothers' doctors for injuries resulting from conduct after their conception but prior to their birth, some courts have gone so far as to recognize claims for injuries resulting from preconception conduct. See, e.g., Renslow v. Mennonite Hospital, 67 Ill.2d 348, 367 N.E.2d 1250 (1977) and Monusko v. Postle, 175 Mich. App. 269, 437 N.W.2d 367 (1989).

5. Compare Ill. Ann. Stat. ch. 38, (Smith-Hurd Supp. 1989) §§ 9-1 (first degree murder) and 9-1.2 (intentional homicide of an unborn child); Minn. Stat. Ann. § 609.185 (West Supp. 1989) (murder in the first degree) and § 609.2661 (West 1987) (murder of an unborn child in the first degree).

6. 410 U.S. at 162.

7. 410 U.S. at 163.

8. 410 U.S. at 163-164 (noting that late abortions could not be barred if the preservation of the life or health of the mother was involved).

9. 410 U.S. at 155.

10. Minn. Stat. Ann. § 609.266 to 609.269 (West 1987).

11. Ill. Ann. Stat. ch. 38, §§ 9-1.2, 9-2.1, 9-3.2, 12-3.1 and 12-4.4 (Smith-Hurd Supp. 1989).

12. N.D. Cent. Code §§ 12.1-17.1-01 to 12.1-17.1-08 (Supp. 1989).

13. Wash. Rev. Code Ann. § 9A.36.021 (West Supp. 1989).

14. Stallman v. Youngquist, 125 Ill.2d 267, 531 N.E.2d 355 (1988) (reviewing developments generally, and in Illinois in particular).

15. Monusko v. Postle, 175 Mich. App. 269, 437 N.W.2d 367 (1989) (reviewing recent preconception tort cases).

16. Cal. Penal Code § 270 (West 1988).

17. Roe v. Wade, 410 U.S. at 162.

18. Note, The Criminalization of Maternal Conduct During Pregnancy, 64 Ind. L.J. 357 (1988-1989) (reviewing the Stewart case and urging restraints on the use of criminal penalties against pregnant women); Note, Maternal Rights and Fetal Wrongs: The Case Against the Criminalization of "Fetal Abuse," 101 Harv. L. Rev. 994 (1988) (similar).

19. See, e.g., Okla. Stat. Ann. tit. 10, § 1101 (West Supp. 1989) ("deprived child" includes some children born in a condition of dependence on a controlled dangerous substance) and § 1130 (West 1987) (circumstances under which a deprived child can be subject to termination of parental rights); In re Ruiz, 27 Oh. Misc.2d 31, 500 N.E.2d 935 (Com. Pl.1986) (finding of child abuse by juvenile court can be predicated solely upon mother's prenatal conduct involving heroin use). Compare Matter of Steven S., 126 Cal. App. 3d 23, 178 Cal. Rptr. 525 (1981) (finding a fetus is not a person able to be adjudged dependent by a juvenile court and thus a pregnant woman's detention was illegal, but in a setting where the prospective mother was allegedly mentally ill and where the state had not afforded her a commitment hearing); Matter of Dittrick Infant, 80 Mich. App. 219, 263 N.W.2d 37 (1977) (Probate Code does not permit custody order regarding unborn child, though Code amendments are desirable).

20. Matter of Adoption of Doe, 543 So.2d 741, 746 (Fla. 1989). See also State ex rel. Lewis v. Lutheran So. Ser. 227 N.W.2d 643 (Wis. 1975) (prebirth acts of father constitute child abandonment).

21. Sherman, Keeping Baby Safe From Mom, 11 Nat. L.J. 1 (Oct. 3, 1988).

22. Taft v. Taft, 388 Mass. 331, 446 N.E.2d 395 (1983). Legal See also Labor of Love, A.B.A. J. 32 (Dec. 1986) (describing case of pregnant, brain-dead woman whose life support system was ordered continued at the prospective father's request not withstanding her parents' objections).

23. Consider, e.g., Lipton and Campbell, The Constitutionality of Court-Imposed Birth Control as a Condition of Probation, VI J. of Hum. Rts. 271, 298 (1989) (terms of probation for pregnant woman convicted of attempted child abuse of born children included woman's submission to urinalysis testing for drugs and enrollment in parenting and prenatal care classes).

Senator COATS. Thank you both very much for some very stimulating testimony and some challenging assertions here. I wonder, Mr. Parness, you made the statement that you supported the rights of the State to intervene in situations where there clearly was an overriding State interest. I don't know how much testimony you have heard this morning, but even if you didn't hear it all, I am sure you are aware of the substantial risk that occurs to the unborn through substance abuse by the mother. In fact, some have even indicated that the effects on the unborn, on the fetus, is up to ten times the same effect on the mother; that is, for every dose the mother takes, when it is transferred to the placenta, that factor is up to ten, which is clearly substantial. Doesn't that almost make a prima facie case for State involvement in providing for protection? Doesn't that automatically clear away the fine distinction that you were asking about?

Mr. PARNESS. I think it does, and what has been frustrating to me is review of laws wherein State after State will refuse to intervene on behalf of the unborn simply because the statutory language has not been written to cover it. What has also been frustrating is a situation in which the State has attempted to intervene where there has been misunderstanding of the decision in ROE v. WADE and therefore people come to believe that a woman during her pregnancy has a right to do with her body what she wishes and that ROE v. WADE affirmed that right and therefore coercive State conduct to protect unborn human life is impossible.

I think that is a misreading of ROE v. WADE. I think that in ROE v. WADE the Supreme Court did recognize the strong and legitimate State interest in protecting the potentiality of human life, and in a fair number of these settings we are not talking about countervailing the constitutionally protected right to terminate pregnancy, but rather what we are talking about is the interest of the prospective parent, be it the mother or the father, in this setting today the mother, to undertake what very typically is evil conduct.

It is a very different setting, and there seems to be a misunderstanding of the decision in ROE, because a fetus is not a person within the confines of the Fourteenth Amendment to the Federal constitution, but the fetus cannot be a person, cannot be protected under other State laws, and I think that is simply erroneous, and I think there is beginning to be some development in the States' beginning to recognize the differentiation between situations involving pregnancy termination being deciding by the mother and other situations involving the State's protection of human life, but there is no concern at all about the decision-making with respect to child abuse.

Senator COATS. So in your view, we wouldn't need a separate legal finding that life begins at conception?

Mr. PARNESS. No.

Senator COATS. You think ROE v. WADE provides that?

Mr. PARNESS. I think ROE v. WADE provides that in the sense of the State's interest in protecting human life. Now, at times protecting human life, as I indicated, can be protected by equating the born with the unborn. For example, in the setting in which a medical doctor treats a pregnant woman, is it true that a doctor has a

duty now, in terms of the pregnant woman as a patient, but the unborn child as a patient, and there are States in which very often the unborn child is just as much a patient of the doctor as is the mother, at least in the setting in which parental interests, or the child's interests and the mother's interests are in harmony.

But even without an equation between the unborn and the born, if we simply stick with an assertion that we are trying to protect potential human life, even if a human life begins at the point of birth, it seems to me it still would be true that the State would be involved in even protecting human life even when we fail to characterize the unborn as a person. And I think, as I developed, for example, in the tort area re: conception, where activity undertaken by people today that there was harm to those born alive tomorrow who weren't even conceived at the time of the activity is a recognition that does not have to be characterized under the laws of the unborn for the law to protect that individual in terms of the future happenings.

Senator COATS. Do you have any problem with Mr. Goldsmith's outlining of testing in different stages of fetal development, as well as postdelivery testing and follow-up and then using that as a basis for a decision as to whether or not to go ahead and prosecute?

Mr. PARNESS. I heard him suggest some concern about testing prior to birth in terms of deterring women from seeking medical advice with respect to their pregnancy if, in fact, there is a fear that results of the tests are going to be reported to the State. I think that is a legitimate concern, and I have heard that concern asserted elsewhere. I am not sure that I have seen empirical evidence with respect to how much deterrence there really is, and I think there ought to be some study, but I think that is a legitimate concern.

I am not sure that that concern about the chilling effect on the pregnant woman hasn't been overstated. I hear that concern about the chilling effect on the pregnant woman stated by the same people who will turn around and then tell you these people are addicted and they don't really know what they are doing, and how they can make the argument that they are addicted and don't really know what they and are not responsible for their conduct and at the same time talking about how this kind of testing will cause them to make a decision and deter them from coming in. I don't see the consistency. I think we do need some better evidence than we have about the chilling effects, and I am not that familiar, but I am also sympathetic with the view that he took with respect to the ability to act on the chilling effect. I think we are beginning to see outside of Indiana the development of laws that recognize much more significantly the ability of the State to intervene.

Senator COATS. Mr. Goldsmith, I thought your outline of steps that you would suggest to be a pretty reasonable approach to the significant problem that we are trying to deal with. Do you view the lack of treatment programs or programs in which to channel identified mothers into, as a mitigating factor in terms of how you might proceed?

Mr. GOLDSMITH. If I might, let me make a response on the front end of your question and then complete the thought. It's not so much that I think it is impossible for, or even inappropriate to

prosecute the mother who is giving her fetus cocaine as I think that isolated prosecutions, rather than a more consistent approach, tend to be short-sighted. Similarly, one the reasons that narcotics enforcement has failed generally is that too few people have a realistic risk of being picked up, and that is why I tried to kind of stair-step the analysis.

Senator, I raise that primarily because it seems to me we ought to always figure out where we are going, and my experience as former chairman of the Governor's Drunk Driving Task Force in Indiana and being active in the national research area has been that people who are involuntarily sent to substance-abuse counselling, especially in the alcohol area, have as high a success rate as those who walk in on their own, and therefore I am fully prepared to use the club of the State to protect and save the baby. But I think that it is apt to be most constructive if it is linked with treatment for the mother, and I don't think that the mother's activities are necessarily mitigated or should be mitigated because of the absence of counselling, but rather that the presence of counselling provides a more hopeful long-term solution, and I think I can get her there through my leverage, if you will.

Senator COATS. Mr. Parness, do you think that ought to be a mitigating factor? How do you think the courts would deal with a situation where prosecution was, say, applied on an across-the-board basis but yet the defense was, "Well, there weren't sufficient treatment programs available."

Mr. PARNESS. I think there ought to be a mitigating factor in any possible criminal prosecution. I think Mr. Goldsmith ought to be very cautious about widescale prosecution. I am particularly concerned with an attempt to prosecute in Rockford, IL, for instance, outside of the community in which I live in which a child was born exposed quite significantly to drugs and died 43 hours after birth, and the prosecutor was unable to get an indictment. And the reason, according to the press at least, is that the grand jury failed to indict because the grand jury believed that there were constitutional rights that this pregnant woman had with respect to doing with her body what she wished.

I just think that is misinformed, and I think selective prosecutions might serve to educate the population that for those kinds of prosecutions, protective rights don't exist, in much the same way that you and I can't choose to go to a movie leaving our infant at home unattended. There are limits that the State can legitimately impose on us when we have responsibilities that differentiate us from others, and so I think some selective prosecutions are in order.

I think if Melanie Green in Rockford had come to the court in a criminal prosecution for intentionally abusing her child said, "Your Honor, I tried to get myself rehabilitated, I tried to get into a drug rehabilitation program but there was just none available," yes, I think that is a mitigating factor in criminal prosecution. I am not sure it is a mitigating factor in terms of ultimate responsibility she bears for harm to her child in the context, for example, of a child custody proceeding. That is very different.

Senator COATS. One last question and we can move on. Mr. Goldsmith, do you need additional statutory authority from State or the

Federal Government to do what you think is necessary to effectively deal with this problem?

Mr. GOLDSMITH. As the Senator understands it, that is an enormously complicated question. We in Indiana don't have sufficient legal tools to protect the fetus from abuse the same way we do the child, and that may very necessarily need attention. That is a State matter. But I think that we could approach a better solution than we have today without additional criminal laws if the Congress would give attention to moving up the AFDC period to inception and extending the SOBRA care laws postdelivery. Then I think we might have sufficient clubs to at least piece together an interim response.

So I would recommend to the Senator that at least an evaluation be done at the national level, and then for the Indiana General Assembly members who are paying attention to the testimony today that some consideration of extending the protection of fetal rights also occur.

Senator COATS. Thank you. I think that is an important consideration you asked us to take, so we will do that, and we appreciate the testimony of both of you.

What we are going to do is take a very brief 5 to 8-minute break here. People have been sitting for a long time. And then we will reconvene very shortly with our fourth panel.

(Short break.)

Senator COATS. All right, we will reconvene. Thanks again for your patience. Our fourth panel, Dr. Dev Maulik, Director of Obstetrics and Perinatology of the Truman Medical Center, Kansas City, MO; Mayor William Hudnut, III; and Pamela Carter, Executive Assistant for Indiana Health and Human Services here in Indianapolis.

We thank our panelists for your presence, and we will follow the procedure we followed in the previous three panels, by having all three testify and then opening it up for questions, and we will start with you, Mr. Mayor. Thank you very much for testifying before the committee.

STATEMENT OF HON. WILLIAM H. HUDNUT, III, MAYOR, ACCOMPANIED BY DEPUTY MAYOR PAULA PARKER-SAWYERS AND JIM MORRIS, INDIANAPOLIS, IN

Mayor HUDNUT. Thank you very much, Senator Coats, for this privilege.

First of all, as the Mayor of Indianapolis, I would like to welcome you and your colleagues from Washington to our city. We are very glad to have you here and appreciate that you held your hearing here in Indianapolis and here in one of our fine schools in the Wayne Township School System.

I also thank you for giving me an opportunity to visit with you about the infant mortality problem. It is of grave concern to our city. We prefer to talk about it in terms of a "healthy babies" problem and establishing a campaign for healthy babies here rather than just weeping and wailing and gnashing our teeth and worrying about how we can address the negative of infant mortality.

But the fact of the matter is that Indianapolis, according to the latest statistics available, has the highest rate of infant mortality among any major city of the country, particularly in the minority population where the figures show 24.6 deaths per 1,000 live births, and that is a pretty high statistic. We are very concerned about the way in which we can bring this statistic down, and we want to do everything that we can as a community to marshal our resources to that end.

We feel as though the problem is basically caused by a lack of prenatal care, and if somehow we can improve prenatal care, we can address the problem of infant mortality. A 1988 Institute of Medicine Report on Prenatal Care said, "There is widespread agreement that prenatal care is an effective intervention strongly and clearly associated with improved pregnancy outcomes."

Well, about a year ago the City-County Council set up a Task Force on Infant Mortality, and they issued a report last January which was produced through a cooperative effort by some 150 people in our community, members of the City Council, health care professionals, public officials, educators, civic leaders and so on, and they sought to identify the factors that are contributing to the statistics that are such a problem for us.

It seems to me, as I have analyzed their report and thought about the full issue, that there are four aspects of the problem. The first is the health care system itself and whether or not it is adequate. Dr. Lorin Peterson is in the room, and there are other people in the room who are much better equipped than I to discuss this problem, but reduced to layman terminology, which is all that I can speak in, it seems to me as though we have to have a system in place that is designed and comprehensive and not just ad hoc, so that we can, in a coordinated way, address the problem. That means that we have to work with professionals in the field to develop this kind of a system.

We have been trying to do that. We are very grateful for the help we have received from officials of HHS. We have also sought to work with State officials. It is a cooperative effort.

The second part of the problem is access to the system once the system is in place. There are a lot of people who don't understand how to access the system and who have no idea that there is a Wishard Hospital there for them in Indianapolis, who have no idea of how to get help when they are pregnant, and so they sit home and tend to watch TV and eat potato chips and drink cokes and think that that's all that they need to do in order to have a well-nourished baby born. That is not the case. We have talked with some of these people, and it is just a question really of getting them into the system so that they know that the care is available, they know how to receive the care, and this leads to the third part of the problem, which is education.

We want, in the long run here in Indianapolis, to develop, with the help of the private sector, an educational campaign that will spread around the message that health care is available and that professional help can be received if you access the system, and, of course, the fourth part of the problem, after I speak of the system itself and the access and the education, is the funding.

Now, we are looking at a special effort here in Indianapolis, which I think is considerable, to develop a coordinated approach which, if you count all the resources together over a 3-year period, will probably have a budget of some eight to eight-and-a-half million dollars. This is, in a sense, new money, newly discovered resources, that we have pulled together in order to address this problem.

I am pleased that the City Council, in the 1990 budget, has authorized a million and a half dollars for this purpose, and we are hoping that maybe next year they would do the same. The funds will be used for increased prenatal care in neighborhoods that we identify as target areas, geographic areas within the city that have high infant mortality rates where teams of professionals will be sent out into the neighborhoods to try to give more people access to the system and to give them professional care. This is part of our campaign for healthy babies.

We have set up a task force which is co-chaired by one of our private-sector leaders, Jim Morris and our Deputy Mayor, Paula Parker-Sawyers, who is also in the room this afternoon, and they are going to see what they can do to coordinate the resources that are available at the Federal and State and local level and in the private sector to address this problem. That is where the eight and a half million dollars comes from.

We think that it is very important to emphasize the cost savings that can be effected. I think the prenatal care is cost-effective. I am told that for every dollar you spend on prenatal care you save at least $3.38 in high-tech care. And some of these babies that we see—and we did take a tour of Wishard Hospital and Riley Hospital, and I brought a little picture book, scrapbook, call it what you want, briefing book, on our tour that I'd like to give to you, Senator, because it graphically illustrates the problem. Some of these babies are costing a hundred thousand dollars to keep alive at a low birth weight, and they are malnourished to start with.

So we have set up this task force, we have allocated this money, the total budget of public and private sector resources that we have been able to find here amount to about $8 million, as I said, and we are beginning to undertake to solve this problem. We want to bring these statistics down. We are embarrassed by them, we are concerned about them, we have compassion for the kind of human tragedy that is in back of these statistics. Healthy babies mean a healthy city. Or to paraphrase the United Negro College Fund Motto: A child is a terrible thing to waste, and we want to do everything we can as the capital city of this State to bring the statistics down, to have more healthy babies born and to be a part of the solution to this problem rather than a part of the problem itself.

I ask the question: What can the Federal Government do to help us? And it is so easy and tempting for a mayor to come to a Federal official like Oliver Twist did many years ago with his hands outstretched, "Please, sir, may I have some more?" And I don't want to be guilty of that, and I don't want you to think I have come here with a tin cup in my hand saying, "We need more Federal money," and yet the fact of the matter is that if we did have some grant money for care coordination, which would enable us to monitor the child from the womb on through, it might help us. And there are

ways in which we can affirm a partnership between the different levels of the public sector to the end that we will all benefit. And I would hope that you would leave this hearing perhaps with some ideas about more effective ways in which the Federal Government could help us as we seek to address this problem.

There are some experts here, so I will cease and desist, but thank you for letting me just make these few rambling remarks.

[The prepared statement of Mayor Hudnut follows:]

PREPARED STATEMENT OF MAYOR WILLIAM H. HUDNUT III

I. Senator Coats, distinguished guests, I thank you for giving me the opportunity to address you today as part of this hearing. On behalf of the citizens of Marion County, let me say we appreciate your efforts to solicit the input of various experts and concerned individuals in our community on these subjects which threaten and jeopardize the health and welfare of Indianapolis.

The topic I have come here to address is that of Infant Mortality, which as you are aware, is a topic of grave concern in our City. In the next few minutes, I plan to provide you with some background on the seriousness of the issue, discuss how it impacts our community, and then conclude by exploring the mechanisms we have put into place to resolve the problem.

II. According to the latest statistics published by the Children's Defense Fund, our City has the highest black infant death rate of our country's 22 major cities. Indianapolis recorded 24.6 deaths per 10,000 live births among black infants in 1986. The statistic that is the result of a fragmented prenatal care system.

After exhaustive study and research on the local, state and national levels, we have determined that inadequate prenatal care is a major cause of the problem. Several major barriers to quality prenatal care have been identified and documented as contributing to the high death rate: the cost of prenatal care is prohibitive; the number of health care professionals delivering care is limited; problems with the way our health care system is organized; and a myriad of cultural and educational barriers which impede the delivery of care to expectant mothers.

Many national studies support this contention that better prenatal care is the key to solving this problem. A 1988 Institute of Medicine report on prenatal care said, "there is widespread agreement that prenatal care is an effective intervention, strongly and clearly associated with improved pregnancy outcomes." The National Commission to Prevent Infant Mortality has recommended increased wide-ranging efforts to make the healthcare of expectant mothers a priority.

Factors found to impact inadequate prenatal care include the age of the mother, low maternal education, low income, minority status and single marital status.

III. Indianapolis' staggeringly high infant death rate was the subject of a 1988 study by the City-County Council Task Force on Infant Mortality. The Task Force report, issued in January, was produced through the diligent work of over 150 committee members, including health professionals, public officials, educators, civic leaders, etc. The task force sought to identify the factors that contributed to the high infant mortality in Marion County and develop strategies and plans of action to reduce the rate.

The report found that inadequate care was directly correlated to higher infant death rates. In 1987, more than 5,000 pregnant women in Marion county received less than adequate prenatal care.

We know that prenatal care is cost effective. Every dollar spent on prenatal care saves at least $3.38 cents in high technology care, according to the Institute of Medicine. One study found that treating five high risk babies would pay for providing care to 149 women.

Recently, I toured the nurseries and clinics of Wishard and Riley Hospitals to gain a better understanding of this complex problem. Two City-County Councillors, Steve West and Glenn Howard, joined Deputy Mayor Paula Parker-Sawyers and I in a first-hand look at the4 excellent, professional care being offered there. Our visit helped us to realize that healthier babies are within reach, if we all pull together.

The costs of not taking action are staggering. For example, in Wishard Hospital, I met a baby named Erica who is being kept alive in the Special Care Nursery. She was born premature, weighing only 1 1/2 pounds at birth. She's up to 6 pounds now, but her hospital bill has already totalled $106,000. The taxpayers of Marion County have to pick up the costs of caring for infants whose parents do not have adequate health insurance.

IV. With the information from the Task Force Report and numerous other studies in hand, the next step toward bringing about a solution to this critical problem was building a community consensus and marshalling the support in both the public and private sectors.

It was our task to let the citizens of our City know that unless we are a healthy city, we cannot be a competitive City. The time had come to turn the "public-private partnership philosophy"—which had became the hallmark of the Indianapolis renaissance—to work on our most pressing human problem.

To date, two key accomplishments have been made in our efforts to combat the problem. First, on August 28, 1989, we announced the formation of a new non-profit organization, known as the Indianapolis Campaign for Healthy Babies, that represents a combined effort to reduce infant death in Marion County. The Campaign, which is co-chaired by Deputy Mayor Paula Parker Sawyers and James T. Morris, is made up of five major committees: finance/legislation; health services; community education, information and mobilization; evaluation and monitoring; and development.

First, the Indianapolis City-County Council has appropriated $1.6 million of its 1990 budget to programs aimed at lowering infant death in Marion County. The funds will for increased prenatal care in those areas identified as "target areas"--that is, those geographic areas found to have the highest infant mortality rates in the City. These are: Southeast and Southwest, the Haughville area, Barrington, Meadows, 38th and Post, and the Citizens neighborhood.

The Campaign is working to obtain tax-exempt status that would enable it to receive tax-deductable contributions and to disburse funds to the appropriate agencies.

The mission of the Indianapolis Campaign for Health Babies is to improve the health of all pregnant women and infants in our community. In order to achieve this goal, we must provide the necessary health and social services that will enable them to have access to and receive the best possible, high quality, affordable care.

Only by eliminating the financial barriers, increasing the capacity of the health care system, improving the way the system is organized, and educating the community about the importance of prenatal care, healthy lifestyles and preventative health care, can we accomplish our overall mission.

V. None of this can be accomplished overnight, and no one agency or level of government can do it alone. It will take a coordinated effort, involving the public and private sectors; local, state and federal government; health professionals, social workers and lay personnel.

Getting the information out and discussing moves us ever closer to our goal of reducing infant death. That's why we appreciate the opportunity to come before you today to address this situation and dialogue about it.

Thank you for listening.

Senator COATS. Thank you very much. We will come back to you with some questions. We will first hear from Pamela Carter, as I said, Executive Assistant to Governor Bayh for Health and Human Services. Thank you for testifying before us and we are looking forward to your testimony.

STATEMENT OF PAMELA L. CARTER, EXECUTIVE ASSISTANT TO HON. EVAN BAYH, GOVERNOR, INDIANAPOLIS, IN

Ms. CARTER. Thank you. Governor Bayh would like to thank you very much for inviting his office to participate in the first of five hearings on drug use and prevention in respect to infant mortality.

The majority of Indiana births are without complications. Nevertheless, there are many births with circumstances that pose a high risk. These include births to women who abuse alcohol and other substances, very young, often unmarried and undereducated women, and births to nonwhite women. These mothers often face disruption of schooling, significant social problems, high rates of repeat pregnancies and public dependency. These realities often doom their children to a cycle of poverty which significantly contributes to poor health, low self-esteem, low educational achievement, frequent removal from their mothers and reduced chances of successful and positive life experiences.

Because alcohol and other drug use during pregnancy results in low-birth-weight infants, a major contributor to the infant mortality rate, reducing this problem will combat both issues.

Governor Bayh has taken decisive steps on several fronts to combat the scourge of drug and alcohol abuse and to lower the infant mortality rates.

One of his first initiatives is with the Prenatal Substance Use Prevention Program in conjunction with the Indiana Department of Mental Health and the Indiana State Board of Health. The purpose is to prevent alcohol and other drug use among pregnant women, thus improving pregnancy outcomes.

We do that on three levels. Number one is primary prevention. The goal of the primary prevention component of the program is to increase public awareness of potential hazards to an unborn baby from substance use during pregnancy. Governor Bayh will be ensuring that the message regarding the harmful effects of drug use is widely disseminated.

And I have here a poster for you to take around the State and back to Washington as an example of some of his public awareness efforts.

What are some of the hazards of using alcohol and drugs during pregnancy? Alcohol may result in low birth weight, facial defects, small head size, learning and behavior problems, or fetal alcohol syndrome. Tobacco may increase the risk of low birth weight, spontaneous abortion, and stillbirth. Marijuana may produce premature delivery, poor visual and light responsiveness, and low birth weight. Cocaine may result in stillbirth, premature delivery, poor motor regulation, high-pitched crying and the inability often of these little ones to be comforted. Heroin may increase the risk of growth retardation, high-pitched crying, frantic sucking, restlessness, and high blood pressure.

The second prevention tier is the goal of the second component of the program, to increase the identification of women at risk for delivering an infant affected by prenatal substance use. There are four regional seminars that have been conducted in cooperation with the Fairbanks Research and Training Institute resulting in 350 health care professionals learning how to screen, intervene, and follow up with pregnant women and exposed infants in September and October of 1989. Approximately 2,500 physician information packets will be distributed to all obstetricians, gynecologists, pediatricians, family practice physicians, and health officers in Indiana.

As was stated earlier in testimony, it is imperative that our health professionals learn to intervene and screen appropriately so that we can get better statistics and recognize and identify those women at risk early.

And the third level of prevention is to improve the management of high-risk pregnant women and infants born with addiction-related problems, through the development of community-based service delivery systems. We have three pilot prevention programs in Lake, Allen and the Tri-Caps area of Pike, Spencer, Dubois, and Warrick Counties.

Directors of the pilot programs are responsible for promoting the prevention efforts in their counties, networking with community agencies to support service delivery for at-risk women and affected children, providing consultation to health care professionals, and case management services to clients.

Directors of these pilot programs will work with the Maternal and Child Health projects, local health departments, and hospitals to identify pregnant women using alcohol, tobacco, or drugs and their affected infants. They will also work toward developing a comprehensive system of treatment and prevention services for women, regardless of ability to pay. An evaluation of the tertiary prevention program will be done to ensure its effectiveness.

The newly created Birth Problems Registry reported that 13 Indiana infants were born with fetal alcohol syndrome and 17 infants with drug exposure in 1988.

The three pilot programs operating as part of the Prenatal Substance Use Prevention Program found that the percentage of pregnant women reporting high-risk level of alcohol and other drug use in their programs was 42 percent in Fort Wayne, Indiana, 50 percent in Jasper, Indiana, and 100 percent in Gary, Indiana.

Other drug initiatives. Earlier this year, the Indiana General Assembly enacted a set of anti-drug laws proposed by Governor Bayh. Among these new laws were statutes calling for drug education curriculum for grades K through 12, taught by teachers trained in drug education. The Governor's antidrug package also amended State law to allow for wellness programs with alcohol and other drug referral and counseling components to be established for all State employees on State property.

Additionally, tax credits will be offered to employers in the event that they use any of their resources to assist their employees.

In May of this year, the Governor signed an executive order creating the Commission for a Drug-Free Indiana. This Commission includes members of 15 different disciplines who come together to

establish statewide antidrug strategies for Indiana. As part of the Commission, State government has formed an Interagency Council Against Drugs that coordinates all State antidrug programs and provides the direction that has been lacking in the State's implementation of State and Federal drug programs. Finally, the Commission has 10 Regional Offices set up throughout the State, not only to act as disseminators of antidrug information to all areas of the State, but also as a means of ensuring that information from the local communities makes its way to the State Capitol.

Next year, the Governor will be proposing a number of further measures, including the formation of a Drug-Free Communities Fund. This Fund will be a pool of State money from license reinstatement fees and court fees imposed on drug felons, combined with Federal block grant money, to fund community-based antidrug programs that include funding for treatment, education, and law enforcement.

Infant mortality. Governor Bayh and the Indiana State Board of Health have developed the Hoosier Infant Initiative which includes a number of innovative programs aimed at reducing Indiana's rate of infant death.

Components of the Hoosier Infant Initiative include: The I.I. Care Clinic, which stands for State Board of Health of Indiana University School of Medicine, Comprehensive, Antenatal, Risk Assessment, Evaluative Clinic.

And this Care Clinic recently opened its doors, and it is a state-of-the-art clinic providing comprehensive services to high-risk mothers statewide. It evaluates women who are at highest risk for adverse pregnancy outcome and provides comprehensive prenatal care. The clinic provides follow-up services to the women and their children, including tracking all enrolled infants to assure that they access and remain in child health supervision at least through age five.

S.O.B.R.A. Governor Bayh proposed and the Indiana General Assembly raised the income eligibility threshold for Medicaid coverage for pregnant women and children by adding an additional $54 million appropriation. This expansion of Medicaid to more pregnant women and children will assure that more women and children will not face financial obstacles for obtaining necessary medical care pre- and postdelivery.

The W.I.C. program has been a long-standing and very helpful nutritional program, serving low-income pregnant and breast-feeding women, women who recently had a baby, infants and children up to age 5 at health risk due to nutritional needs.

Governor Bayh signed a contract with Mead-Johnson, which is an Indiana-based manufacturer of iron-fortified infant formula, which provides the highest rebate on infant formula of any W.I.C. program in the United States. The cost savings from this rebate program have expanded services to another 15,000 to 20,000 Hoosier women and their children. This rebate program is an example of a successful public/private partnership that benefits all Hoosiers.

Finally, there was an hour-long documentary which Governor Bayh appeared in and will be appearing in, that focuses on the causes of infant mortality and what steps can be taken to lower

infant death rates in Indiana. The film was filmed in April and was shown once. The special was developed both as a complete documentary which will be aired as a State Board of Health production and as a prepared package which local TV stations in the State can use as background information to produce their own local specials. Eight Indiana stations in all geographic areas of the State have agreed to use the documentary materials.

Last but not least, the Governor is also co-chair of the Campaign for Healthy Babies, and he would like to commend your office for graciously assisting us and allowing us to assist you in a variety of endeavors. I have had the pleasure of talking with Tom Long, your Health Specialist, recently, and he indicated that you have been working very, very hard to change the formula so that Indiana would get additional resources for the fight against drug abuse in this State. We commend you for that, and the Governor would like for me personally to convey to you that any way that he can help you bring some of the issues to bear to assist you in your fight on the Federal level to obtain additional resources to assist us in the battle against substance abuse and infant mortality he will do. Thank you very much.

[The prepared statement of Ms. Carter follows:]

OFFICE OF THE GOVERNOR
INDIANAPOLIS, INDIANA 46204-2797

EVAN BAYH
GOVERNOR

TO: The Honorable Dan Coats, U.S. Senator

FROM: Pamela L. Carter, Executive Assistant to Governor Evan Bayh for Health and Human Services

RE: Written Testimony Submitted to the Subcommittee on Drugs, Alcohol, Children and Family of the Committee on Labor and Human Resources

Governor Evan Bayh would like to thank you for inviting his Office to participate in the first of five hearings on drug-abuse and prevention, its effect on infants and infant mortality.

The majority of Indiana births are without complications. Nevertheless, there are many births with circumstances that pose a high risk. These include births to women who abuse alcohol and other substances, very young, often unmarried and undereducated women, and births to nonwhite women. These mothers often face disruption of schooling, significant social problems, high rates of repeat pregnancies and public dependency. These realities often doom their children to a cycle of poverty which significantly contributes to poor health, low-self esteem, low educational achievement frequent removal from their mothers and reduced chances of successful and positive life experiences.

Because alcohol and other drug use during pregnancy results in low birthweight infants, a major contributor to the infant mortality rate, reducing this problem will combat both issues.

Governor Evan Bayh has taken decisive steps on several fronts to combat the scourge of drug and alcohol abuse and to lower the infant mortality rates.

THE PRENATAL SUBSTANCE USE PREVENTION PROGRAM

The Prenatal Substance Use Prevention Program is a three tier prevention program funded by the 1988 Omnibus Drug Grant through the Indiana Department of Mental Health and the Indiana State Board of Health. Its purpose is to prevent alcohol and other drug use among pregnant women, thus improving pregnancy outcomes.

I. Primary Prevention

The goal of the primary prevention component of the program is to increase public awareness of potential hazards to an unborn baby from substance use during pregnancy. Governor Bayh will be ensuring that the message regarding the harmful effects of drug use is widely disseminiated.

What are some of the hazards of using alcohol and drugs during pregnancy?

Alcohol -- may result in low birthweight, facial defects, small head size, learning and behavior problems, or fetal alcohol syndrome.

Tobacco -- may increase the risk of low birthweight, spontaneous abortion, and stillbirth.

Marijuana -- may produce premature delivery, poor visual and light responsiveness, and low birthweight.

Cocaine -- may result in stillbirth, premature delivery, poor motor regulation, high pitched crying and less growth than normal.

Heroin -- may increase the risk of growth retardation, high pitched crying, frantic sucking, restlessness, and high blood pressure.

II. Secondary Prevention

The goal of the secondary prevention component of the program is to increase the identification of women at risk for delivering an infant affected by prenatal substance use. Four regional seminars have been conducted in cooperation with the Fairbanks Research and Training Institute resulting in 350 health care professionals learning how to screen, intervene, and follow up with pregnant women and exposed infants in September-October 1989. Approxiamtely 2,500 physician information packets will be distributed to all obstetricians, gynecologists, pediatricians, family practice physicians, and health officers in Indiana.

III. Tertiary Prevention

The goal of the tertiary prevention component of the program is to improve the management of high risk pregnant women and infants born with addiction-related problems, through the development of community-based service delivery systems. Three pilot prevention programs in Lake, Allen, and the Tri-Caps area of Pike, Spencer, Dubois, and Warrick Counties have opened.

Directors of the pilot programs are responsible for promoting the prevention efforts in their counties, networking with community agencies to support service delivery for at-risk women and affected children, providing consultation to health care professionals, and case management services to clients.

Directors of the pilot programs will work with the Maternal and Child Health projects, local health departments, and hospitals to identify pregnant women using alcohol, tobacco, or drugs and their affected infants. They will also work toward developing a comprehensive system of treatment and prevention services for women, regardless of ability to pay. An evaluation of the tertiary prevention program will be done to ensure its effectiveness.

The newly created Birth Problems Registry reported that 13 Indiana infants were born with fetal alcohol syndrome and 17 infants with drug exposure in 1988.

The three pilot programs operating as part of the Prenatal Substance Use Prevention Program found that the percentage of pregnant women reporting high risk level of alcohol and other drug use in their programs was 42% in Fort Wayne, Indiana, 50% in Jasper, Indiana, and 100% in Gary, Indiana.

OTHER DRUG INITIATIVES

Earlier this year the Indiana General Assembly enacted a set of anti-drug laws proposed by Governor Evan Bayh. Among these new laws were statutes calling for drug education curriculum for grades K thru 12, taught by teachers trained in drug education. The Governor's anti-drug package also amended state law to allow for wellness programs with alcohol and other drug referral and counseling components to be established for all state employees on state property.

In May of this year, the Governor signed an executive order creating the Commission for a Drug-Free Indiana. This Commission includes members of 15 different disciplines who come together to establish statewide anti-drug strategies for Indiana. As part of the Commission, state government has formed an Interagency Council Against Drugs that coordinates all state anti-drug programs and provides the direction that has been lacking in the state's implementation of state and federal drug programs. Finally, the Commission has 10 Regional Offices set up throughout the state, not only to act as disseminators of anti-drug information to all areas of the state, but also as a means of ensuring that information from the local communities makes its way to the State Capitol.

Next year, the Governor will be proposing a number of further measures, including the formation of a Drug-Free Communities Fund. This Fund will be a pool of state money from license reinstatement fees and court fees imposed on drug felons, combined with federal block grant money, to fund community-based anti-drug programs that include funding for treatment, education, and law enforcement.

INFANT MORTALITY

Governor Bayh and the Indiana State Board of Health have developed the Hoosier Infant Initiative (HII) which includes a number of innovative programs aimed at reducing Indiana's rate of infant death.

Components of the HII include:

A.. I.I. Care Clinic (ISBH, Indiana University School of Medicine, Comprehensive, Antenatal, Risk Assessment , Evaluative Clinic)

I.I. CARE which recently opened its doors, is a state-of-the-art clinic providing comprehensive services to high-risk mothers statewide. It evaluates women who are at highest risk for adverse pregnancy outcome and provides comprehensive prenatal care. The clinic provides follow-up services to the women and their children, including tracking all enrolled infants to assure that they access and remain in child health supervision at least through age five.

B. S.O.B.R.A. (Sixth Omnibus Budget Reconcilitaion Act)

Governor Bayh proposed and the Indiana General Assembly raised the income eligibility threshold for Medicaid coverage for pregnant women and children by adding an additional $54 million dollar appropriation. This expansion of Medicaid to more pregnant women and children will assure that more women and children will not face financial obstacles for obtaining necessary medical care.

C. W.I.C.

W.I.C. is a special supplemental food and nutrition program serving low-income pregnant and breastfeeding women, women who recently had a baby, infants and children up to age 5 at health risk due to nutritional needs.

Governor Evan Bayh signed a contrat with Mead-Johnson, an Indiana-based manufacturer of iron-fortified infant formula,

which provides the highest rebate on infant formula of any W.I.C. program in the United States. The cost savings from this rebate program have expanded services to another 15,000 to 20,000 Hoosier women and their children. This rebate program is an example of a successful public/private partnership that benefits all Hoosiers.

D. Infant Mortality Television Special

This hour-long documentary which Governor Bayh appears in, focuses on the causes of infant mortality and what steps can be taken to lower infant death rates in Indiana. The special was developed both as a complete documentary which will be aired as a State Board of Health production and as a prepared package which local TV stations in the State can use as background information to produce their own local specials. Eight Indiana stations in all geographic areas of the State have agreed to use the documentary materials.

Governor Bayh commends Senator Dan Coats in his efforts and urges him to continue fighting for additional resources to assist in the battle against substance abuse and infant mortality.

Senator COATS. Thank you, and thank the Governor for his generous offer.

Dr. Maulik, we turn to you last but certainly not least. We appreciate very much your willingness to come and testify, and you may go forward with your remarks.

STATEMENT OF DR. DEV MAULIK, DIRECTOR, OBSTETRICS AND PERINATOLOGY, TRUMAN MEDICAL CENTER, KANSAS CITY, MO

Dr. MAULIK. Thank you, Senator, and I really appreciate this opportunity.

I am an obstetrician. I have been an obstetrician for the last 22 years, specializing in high-risk pregnancy care. I am also Director of Obstetrics and Perinatology at the Truman Medical Center in Kansas City, MO, and Professor of Obstetrics and Gynecology at the University of Missouri, Kansas City School of Medicine. I am privileged to serve on the Health Professional Advisory Committee of the Greater Kansas City Chapter of the March of Dimes Birth Defects Foundation, and I am pleased to have this opportunity to present the views of the March of Dimes on the prevention of perinatal substance abuse. I must add here that we have brought the objectives of the National March of Dimes view, and part of the answer to the question and does not necessarily present their views.

The mission of the March of Dimes is the prevention of birth defects and the related serious problems of low birth weight and infant mortality.

The March of Dimes is deeply concerned about the rapidly increasing incidence of drug and alcohol abuse by pregnant women. Pregnant women who use drugs or alcohol put their babies at risk of being born too small, too soon or with birth defects.

Medical studies show that each year up to 375,000 babies may be exposed in the womb to illicit drugs, which can cause long-term damage to a mother and her baby. Alcohol and all common drugs of abuse cross the placenta and reach the fetus. Substance abuse during pregnancy can result in spontaneous abortion, pre-term delivery, low birth weight, birth defects and impaired memory and intelligence. In addition, women who abuse drugs are at risk for sexually transmitted diseases, including AIDS, which also can be passed on to the fetus.

Fetal exposure to dangerous substances is totally preventable. The manner in which pregnant women choose to live affects their children's health. A pregnant woman must realize that use of alcohol or drugs can harm the fetus and herself. She is the one who makes a choice.

The March of Dimes views pregnancy as an opportune time to provide women with the information needed to make responsible, educated decisions about their own lives and the lives of their children before and after birth. Education is the first step in preventing perinatal substance abuse. And pregnancy is a time in many addicted women's lives when they are most motivated to stop using drugs.

The second step is comprehensive prenatal care that includes drug and alcohol treatment as well as family support services. We

need to reach women during the critical, opportune time of pregnancy to enable them to make healthier lifestyle decisions. We need to involve fathers, many of whom also may be addicted to drugs, and other key family members to help the family stay together and remain free of drugs and alcohol. We must ensure that drug and alcohol treatment and prenatal care are readily available and accessible to the families who need it.

The third step is to develop follow-up programs for drug and alcohol-exposed infants. Medical and social services must involve the entire family to provide the healthiest environment for an infant.

The March of Dimes is working to reduce perinatal substance abuse in several ways:

March of Dimes researchers are investigating the effects of drugs, such as marijuana, PCP and cocaine on newborn health and development.

March of Dimes chapters throughout the country are sponsoring seminars, panel discussions and community education projects to increase understanding of the impact of perinatal drug and alcohol use.

A March of Dimes media symposium on drug use during pregnancy brought together leading experts and the press to bring the public the latest information about the risks of perinatal drug use.

The March of Dimes supports State and Federal programs that help ensure access to early, comprehensive prenatal care for all women as well as coordination of public programs so participants receive all needed services.

Several programs have been designed specifically to reduce low birth weight and infant mortality to comprehensive services to pregnant women and their infants. Unfortunately, these programs are not fully funded and don't reach all women and babies who are eligible.

The March of Dimes recommends expansion of demonstra-tion programs that target drug and alcohol treatment for pregnant women. The Office of Substance Abuse Prevention also currently has allotted $45 million in grants to develop more treatment programs for pregnant women who have used alcohol and drugs.

Funding for all sets should be increased to double the grant funding for the fiscal year 1990.

Medicaid. States should be required to offer maternity and infants health care to all families on 100 percent of the Federal formula.

Comprehensive services provided to pregnant women through the medical program should include substance abuse treatment for those who need it.

The supplemental food program for women, infants and children. The W.I.C. Program should be expanded by $150 million each year for the next 4 or 5 years to reach the entire eligible population. The maternal and child care block grant full funding of $561 million is needed for the MCH block grants, the only Federal program devoted entirely to the health care needs of women and children.

Communities and migrant health centers. These centers should receive an additional $70 million in the fiscal year 1990 to enable all centers to continue their infant mortality initiatives begun in 1987.

The Lund Infant's Assistance Act. This 1987 act principally benefits babies exposed to the HIV virus, which also usually involves exposure to crack. It also provides for infants at risk of abandonment and foster care placement for children abandoned in hospitals by their parents. The act should receive full funding of $12 million in the fiscal year 1990.

The various Federal and State programs serving pregnant women need to be correlated so that each woman who seeks help can now get that health care, nutrition assistance, substance-abuse treatment and other social service that she needs.

The March of Dimes supports programs that promote healthy mothers and healthy babies. The substance abuse is reaching epidemic proportions. We must make every effort to safeguard the health and lives of future generations. I also support these programs that can be so effective in meeting the vital needs of mothers and their babies. Thank you.

Senator COATS. Thank you, Dr. Maulik.

Mayor Hudnut, I would like to ask you a couple of questions on your testimony, which I appreciate very much. The city, clearly, is responding to a significant problem, typical of Hoosiers. We don't wring our hands and cry tales of woe, we say, "What can we do to deal with this problem," and you have formed a task force and outlined areas in which you were involved. The question I posed to you is the same one I posed to Dr. Meyers when I was discussing our efforts both to city, county and State level of dealing with infant mortality. That is, despite our efforts here, are we going to find that all of the facilities and programs and things that we put in place will, in a sense, be potentially overwhelmed by the mortality that results from drug-addicted mothers and how much coordination is there with the antidrug-abuse effort? What I fear is that we will—well, we are mobilizing an effort here, but yet we won't be able to get a handle on addicted mothers.

Mayor HUDNUT. I think you are right. Most of the testimony that I have heard today would indicate that you cannot deal with the infant mortality problem separate from the drug-abuse problem, and I agree with that. And we are aware of that. We, however, began in a more generic way by discussing the infant mortality problem itself and what could we do to bring our statistics down, and the health care professional tells me it is a solvable problem, that with better prenatal care and more access to the system, our statistics can be brought down.

The problem is, on the one hand you have got a solvable problem and on the other hand you have got the escalating problem of drug abuse and its relationship to infant mortality, and I am not an expert in the field. All I can say is here at the local level we are aware of the correlation and our Campaign for Healthy Babies is working with all the different resources in this community that we can find, including those who are involved in the fight against drugs.

I would like to, if I may, Senator, give our Deputy Mayor, Paula Parker-Sawyers, a chance to respond to this, because I think she might be able to add a little bit more. Is that all right?

Senator COATS. Sure. That is absolutely all right. Paula, welcome.

Ms. PARKER-SAWYERS. Thank you, Senator. As the Mayor has said, we, through the Campaign for Healthy Babies, are working with various groups in the city and the task force that Prosecutor Goldsmith talked about. I will, as well, be serving on it as the Mayor's representative, so that we are coordinating our efforts, and we are not leaving out any facet of the community. Again, as the Mayor's representative working with the Indianapolis Public School System in an antidrug message, a program that we are putting together that you will see a tape later that Indiana Black Expo has produced, that we will take to the schools, in a very graphic way, talks about the problems that drug addiction causes. So what you are seeing is a coordinated effort here in Indianapolis and working with every facet of the community, and that's a problem.

Senator COATS. Thank you. Pamela, you outlined some ambitious programs for the State. I am interested in how you are coordinating those with programs like the City of Indianapolis and others. How do those two relate?

Ms. CARTER. Several ways. First of all, the Governor, being honorary co-chairman of the Campaign for Healthy Babies and also State Board of Health being very actively involved in that campaign, we are also an executive committee working very closely with the city in that context. That is one.

Number two is that in terms of State Board of Health and State of Indiana participate and fund maternal child health projects in each and every local health department in the State of Indiana, and also we provide a lot of additional funds for W.I.C. programs and things of that nature. So we talk with each of the local health officers who are part of the local community but also coordinate with the State. And we also are looking at having a number of our testimony from our hearings in Health and Human Services being compiled, and we have listened through the local communities throughout the State to find out ways which they, the people, think we can address the issues of infant mortality and drug abuse more effectively.

Senator COATS. One further question. Your testimony indicated the number of infants that had been born who have drug-addictive problems. Do you have any statistics relative to the number of infants who have died as a result of drug-addictive problems that are through the mother?

Ms. CARTER. No, not at this point. We are beginning that, because we are going to have more information on death certificates, because we more quickly identify causes for death.

Senator COATS. Dr. Maulik, I was interested in your point about involving fathers in this question. This is the first time it has really come up today, and we may be remiss for not raising it earlier, because I think you are making an important point. Has the March of Dimes come up with any specific programs as to how we can involve fathers in this effort?

Dr. MAULIK. Basically, he is sort of part of the general counselling and education program. Part of the problem of this—I am talking from my own personal experience here—is quite often it would not be possible to take a number of the population that I deal with in my hospital-based practice, we have not been able to get all of

them there, but in spite of that, it is the general program of education and providing help in that context rather than a specific program directed toward the father. So it is part of the family involvement, father's involvement, rehabilitation of the father.

Senator COATS. Are you aware of any statistics relative to better success rates if fathers are involved or whole families are involved?

Dr. MAULIK. No statistics in relation to the father to the best of my knowledge, but we know from personal experience that it really makes a substantial difference when the mother has other support beyond the hospital. We feel that beyond the support of the family there is very little concentration that we have. I think the concentration on the family and the father is a major, major component for the future compliance of that patient, that mother, to continue to get help. So I still say from the past personal experience, as well as from a lot of people's experience around the country is a very powerful component to include the family, include the father, and go beyond just what we have in the hospital.

Senator COATS. One final question, both from Mayor Hudnut and Pamela Carter: To what extent do you believe we should incorporate drug testing in both the identification stage and the treatment/rehabilitation stage, dealing with this particular problem? Other witnesses have talked about it earlier. Do you have any thoughts on that?

Ms. CARTER. I have several thoughts and several questions, as well. One is that you can hope that the focus would be on prevention, education and treatment, and we are looking, however, on the whole array of issues that we need to confront it, or we need to make sure that the public safety of all citizens is a mandate. So we have asked that the prosecutor provide us with a lot of information to allow us to evaluate the strengths and weaknesses of our proposal. So we would love that. And we would like to have it focus much more on education, treatment and intervention and prevention.

Mayor HUDNUT. I think, Senator, if the testing were designed for an educational rather than a punitive purpose, I would look with favor upon it. It seems to me as though on a voluntary basis, if we are involved in prenatal care and we are involved with this testing, that it would help us identify a problem and treat it and correct it. But it would seem to me that probably that should be voluntary and that it should be understood there would be no penalties attached to it, except that we want to try to help the mother have a healthy baby.

Senator COATS. We have been struggling all day, every panel, as well as Secretary Bennett, struggling with the question of where do the rights of the mother end, so to speak, and the responsibility of the State begin—by "State" I mean government authorities—in terms of providing protection to those babies and even the mother herself.

Someone suggested that there be routine screening, which would involve testing any time a mother initiates a visit to a prenatal clinic, hospital, or whatever, for identification purposes so that identification of use, abuse, a use of a substance or abuse of a substance could be made and that from then on certain things would be either suggested or required. We really didn't come up with a definitive answer as to just where we ought to go with all that.

I think the real key question raised by the committee, raised by the witnesses and raised by this hearing is this whole question of where we go with using the State's responsibility and authority to protect the life of the infant and how we carefully walk that fine line between differentiating the State's responsibilities and the rights of the mother? But to the extent that we can continue to work together on all that, I think that is an important answer that we have to define.

Well, thank you, Dr. Maulik, Pam Carter, Mayor Hudnut, Paula Parker-Sawyers for your testimony and participation in this hearing, and thanks to each of you in the audience who have patiently sat through what I thought was some interesting testimony, and hopefully will provide to not only the Senate Subcommittee on Children, Family, Drugs and Alcoholism some very valuable testimony from the Hoosier heartland, which is the fountain of a lot of wisdom, in my opinion, but also provide some impetus to programs that are under way at the State and local levels here in Indiana, and hopefully we have been able to enlighten those of you who attended. It certainly was enlightening to me. We appreciate your attendance, your patience, and this hearing is now concluded.

(At 3:15 p.m. the Subcommittee adjourned subject to the call of the Chair.)

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